Thesis presented for the Degree of Ph.D.

by

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Medical Liability and the Law of Negligence

Faculty of Law
University of Edinburgh
1992

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Abstract

Contents:

Acknowledgments

I should like to thank my supervisors, Mr (now Professor) J.W.G. Blackie, Dr R.A.A. McCall Smith and Dr H.L. MacQueen, and also my parents, all for their kind and unflagging encouragement and patience.

I should also like to record my gratitude to the staff of _inter alia_ the following libraries/organisations for their help:

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Declaration

In terms of University of Edinburgh, Faculty of Law, Postgraduate Study Degree Regulation 3.4.7, I declare that this thesis has been composed by me, and that the work is my own. Some of the basic research material has been incorporated in two published articles, referred to in the thesis: Further Reflections on Medical Causation, A. F. Phillips, 1988 S.L.T. (News) 325, and Medical Negligence and No-Fault Compensation: Background to the Current Debate, A. F. Phillips, 1989 J.L.S.S. 239.

A. F. Phillips

Part I

Chapter I

Introduction and Summary

The law of medical negligence raises, in microcosm but arguably acutely, many issues facing the law of delict and tort. This is so because most issues confronting the wider law - such as compensation - are at least equally relevant to medical negligence. There are other, stronger, reasons. These are that medical negligence is at once an unusual and idiosyncratic field; something relatively rarely appreciated. Why is this the case? The law regulates many other professional activities, all of which are likely to be more difficult to regulate than those of the ordinary non-professional man simply because they are outwith the normal experience of the non-specialist. The practice of accountants, of engineers, of ship-designers and of many others may be classified partly or wholly into business and applied scientific spheres of discourse. These examples, like many reparation claims appearing before the courts, may perhaps fall into one or other reasonably clearly delimited category. By contrast, the practice of clinical medicine involves science - but with a leavening of less-quantifiable artistry. Whether that artistry truly has a characteristic of not being based upon rigorously logical scientific premises, or perhaps partly masks a subliminal or subconscious application of logic and pattern-recognition, is open to consideration. The science upon

which it is based demonstrates a vigorous, hydra-headed development. With the mapping of the human genome presently being undertaken, a single example of "leading-edge" research, many other areas are only slowly yielding their mysteries. Combined with the "professional" element and its splendidly variegated practice, the discipline of medicine, it is submitted, is unusual if not unique in the difficulties which it presents to regulation by the law.[1] As Lord Bridge has put it:

> "[L]itigation in the field of medical negligence continues regrettably to grow in volume. The growth is probably attributable to two principal causes: first, the greater awareness of patients of their legal rights and a greater willingness to enforce them; secondly, the ever increasing sophistication of medical procedures. It is ironic but perhaps inevitable that the further advances medical science makes in being able to offer potential cures for conditions previously incurable or fatal, the more the medical profession lays itself open to attack in respect of the mistakes which can occur in the highly complex and delicate procedures necessary to make the cures effective."[2]

This eminent lawyer's concern over the incidence of medical negligence finds an echo in a recent study of deaths

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[1]The aetiology of disease being a prime example which is unlikely ever to disappear, and requiring a rational legal analysis of causation. Unfortunately there is anecdotal evidence that these characteristics of medical practice and related litigation can place barriers in the way of those who suffer negligence: Brain Damage due to Blocked Tracheostomy Tube: A 12-year Saga, D. Brahams, 1989 Lancet 55.

[2]Foreword by Lord Bridge, in Medical Negligence, M.J. Powers and N.H. Harris, Butterworths, 1990.

following operative procedures;[3] especially anaesthetic complications.[4] Wider ethical and legal debates, for example covering genetic[5] and embryo[6] research, in-vitro fertilisation[7] and other possibilities perhaps unimaginable a few decades ago demonstrate the need for a system of law not only able to analyse such developments in terms of existing values and concepts, but also one which can regulate and adapt to the fundamental and changing nature of the discipline under scrutiny.[8] It is submitted that it

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[3]Report of the National Confidential Enquiry into Perioperative Deaths, 1990, covering deaths within thirty days following surgical procedures between January 1990 and December 1990, considered infra.

[4]"The difference is that, in general, surgeons don't kill but incompetent anaesthetists can." Per Dr. John Lunn, anaesthetic clinical co-ordinator of N.C.E.P.O.D. study (supra), quoted in N.C.E.P.O.D.: Surgeons and Anaesthetists could do better, L. Dilner, 1992 B.M.J. 1071, at p. 1071.

[5]See generally Law and Medical Ethics, J.K. Mason and R.A. McCall Smith, third edition, Butterworths, 1991, chapters 6 and 16.

[6]Discussed in Law and Medical Ethics, cit. sup., chapter 17. Research utilising embryos is now regulated under the regime introduced under the Human Fertilisation and Embryology Act 1990 (c. 37). To borrow a phrase, much ink has been spilt on this subject, but The Human Fertilisation and Embryology Act 1990, P.A. Wiewiorka, 1991 S.L.T. 65 gives a useful outline of the provisions, and Rights, Restraints and Pragmatism: The Human Fertilisation and Embryology Act 1990, J. Montgomery, 1991 54 M.L.R. 524 a discursive analysis.

[7]See Human Fertilisation and Embryology Act 1990 (supra) and inter alia the issues raised in, Assisted conception and clinical freedom: whose freedom is it? D. Morgan, 1990 N.L.J. 600.

[8]In Scotland, it is arguable that the system of extensive written pleadings gives parties fair notice, as does the practice of Health Boards in making case notes available to "third doctors" for assessment, perhaps reflecting some movement towards greater openness: the Access to Medical Reports Act 1990 being an example. In England, this trend is reflected in formal

is these characteristics of the practice of medicine which render it of especial interest to lawyers, and to the architects of the law.

The law, it is thought, should provide a system of analysis and substantive provision which must above all be rational, ethical and just. This thesis therefore attempts firstly to assess these qualities in the present system in the main topics in the law of medical negligence, i.e. the background to, and basis of, liability, the standard of care and causation.

It will be argued that the aims stated above are not fully satisfied.[9] In attempting to establish this, it is hoped that this thesis may fulfil a descriptive role in summarising the appropriate substantive rules. This provides a necessary foundation for the final goal of the work, which is an attempt to devise a reformed general approach which, it is submitted, may provide at least a starting point to satisfy these general aims in addition to those which emerge during the thesis and are summarised below.

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procedure in personal injury litigation. See, The impact of High Court/county court procedural changes on personal injury litigation, I. Goldrein and M. de Haas, 1991 N.L.J. 1699 and [E]nding "forensic blind man's buff", C. Dyer, 1987 B.M.J. 1407.

[9]Cf. Damages for Personal Injury, N. McKinnon, 1992 J.L.S.S. 21.

The law of medical negligence occupies no special place in the jurisprudence of this country. Despite this, or partly because of it, difficulties exist both in the substantive rules applied to such liability, constructed in the same way as any other action in negligence, and also in the delays[10] and other obstacles which defenders must endure and surmount as much as pursuers.[11] Although Scotland has traditionally emphasized fair notice in its system of detailed written pleadings, the risks of delay and obfuscation in complex litigation on medical negligence are present. Mustill L.J., commenting in the Court of Appeal on the (then) English procedure in Wilsher v. Essex Area Health Authority, said:

> "..I cannot part from the appeal without saying something about the history of the action. I do so, not to criticise the practitioners who conducted the case, but to draw attention to certain features of medical negligence litigation as currectly conducted in England and Wales...[T]he first feature speaks for itself: it is delay. The events in question happened in the first two months of Martin Wilsher's life. He is now aged 7 1/2 years. Surely this will not

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[10]Considered infra.

[11]For example, the Royal Commission on Civil Liability and Compensation for Personal Injury, publ. 1978, Cmnd. 7054 (the "Pearson Report") found that although 85% - 90% of all claims in tort were successful, only 30% - 40% of those brought for medical negligence succeeded (paras. 78 and 1326) and that such cases also took longer than the norm for personal injuries actions generally (op. cit., para. 242 and Table 129, vol. II).

> do.....[T]hey should not have to wait so long. Secondly, the procedures adopted for the trial were such as to make the trial quite unnecessarily difficult to conduct, and to create a real risk of injustice...[N]o particulars were ever given of the persons said to have been negligent, or of when or how they were negligent. The defence was served during May 1981. It said nothing...[N]o request for particulars, notice to admit or interrogatory was served by either side....[A]s was stated before us, it was fought "in the dark" "[12]

The general aims stated above beg the question of how such a large - and ambitious - task is to be approached. Implicit in any argument for reform is the assumption that the present approach is unsatisfactory. Accordingly, the evidence and arguments in support of this will be considered. At the time of writing, there is remarkably little evidence for the perceived increase in claims for medical negligence.[13] The available data are at present minimal and have provided little assistance in detecting trends, although an increase in the sizes of settlements and awards, and probably also of incidence, appears to be generally perceived.[14] The writer has been able to discover

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[12]Per Mustill L.J., Wilsher, [1986] 3 All E.R. at p. 829f - 830e. It should be noted that the procedure in the English system of personal injury litigation has been improved since this: described in, The impact of High Court/county court procedural changes on personal injury litigation, I. Goldrein and M. de Haas, 1991 N.L.J. 1699 et seq. In Scotland, the Administration of Justice Act 1982 provides a mechanism for investigating potential claims, and case notes are often released by the Health Board (or Trust hospital) to an independent doctor for assessment of claim potential.

[13]These trends are discussed infra, particularly in the context of reform.

[14]Discussed infra, especially in the context of reform.

very little useful information, but has been encouraged to find this general paucity confirmed in these terms:

> "[I]t is not presently possible to identify the number of medical accidents that occur each year or the number which result from negligence, because this information is not collected. It is clear, however, that over the last 10 years or so the number of claims for medical negligence has increased".[15]

Assuming that an increase in the incidence of claims does exist, the present writer argues that, prior to any consideration of reform, it is fundamental to look behind the law to consider its aims and objectives. Only after evaluating these, and concluding that they are in general valid even though subject to alteration in the light of principle and indeed practice,[16] will it be possible to construct a suitable response to the issues raised.

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[15]Medical Negligence, M. A. Jones, Sweet and Maxwell, 1991, at p. 3, citing inter alia Medical Negligence: Compensation and Accountability, D. Harris et al., King's Fund Institute, 1988, at p. 11. Jones also notes that the introduction of Crown Indemnity in 1990 will also mark the start of recording of claims made under its auspices. This, of course, will exclude claims in respect of general practitioners and private hospitals. The Central Legal Office of the Common Services Agency is understood by the present writer to be embarking upon computerised record keeping of negligence actions, although these would pertain only to cases involving N.H.S. practitioners acting within the scope of their employment and is presumably now overtaken in completeness by Crown indemnity. The present author has been unable to obtain any meaningful data from these and many other sources. The data being collected currently are probably too recent to display any trends, and remain incomplete in that non-N.H.S. and general practitioners remain outside the scheme. Probably the most satisfactory (English) data are those published by the King's Fund study, supra.

[16]For example, as a result of the principle of "scarce resources".

Thereafter, the writer will put forward his proposals in implement of these objectives.

Summary

Having considered the form of the work, let us now summarise its content.[17] This focusses upon the case-law in Scotland and also in England.[18] This approach excludes an otherwise purely comparative study, although other systems of jurisprudence will be considered in relation to reform. Such a task is outwith the scope of the present work.

The topics in the law of medical negligence selected for analysis have been so chosen because, it is submitted, they represent the essential core of the subject and therefore a suitable structure for the thesis.[19] Accordingly, it is submitted that this constitutes a logical, systematic and well-established approach. The thesis concentrates mainly upon the common law relating to doctors working within the National Health Service, and

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[17]An examination of the entirety of the law of medical negligence in the United Kingdom is beyond the scope of this thesis. See generally, Medical Negligence, Michael A. Jones, Sweet & Maxwell, 1991.

[18]In essence, the English and Scots law is the same; the cases appear to be freely cited in both jurisdictions. Similarly, the National Health Service, and medical training, seem to be very similar on a U.K.-wide basis.

[19]Material published after the end of March 1992 has not been included in this thesis.

excludes pharmaceuticals, medical machines and strict liability.

After considering the historical background to the claim for damages for medical negligence and the present bases of liability,[20] the standard of care, and the fault principle will be examined. The law relating to consent will be included only insofar as relevant to the main principles. This is because a comprehensive examination of this topic requires a separate, major work.[21] The principles of causation, and the writer's proposals for reform will then be considered. Again because of constraints of space, procedural aspects of the law such as expert evidence, and prescription and limitation, are not considered discretely but are introduced where appropriate in the context of these major topics. The overall aim is thus to consider the applicability and suitability of the main principles of delict and tort to the law of medical negligence. In turn, the rationality and ethics of the law in this area, and how these might better be served by reforms, will be discussed.

It will be argued that the test for the standard of care, the fault principle generally and the rules of

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[20]The draft Bill introduced by Rosie Barnes in an attempt to establish a no-fault compensation scheme is not discussed, as it is unlikely to be brought before Parliament again in the same form.

[21]A Patient's Right to Know, Sheila A. M. McLean, Dartmouth Publishing, 1989, contains a comprehensive examination of the law, practice and wider issues raised in relation to consent.

causation are unsatisfactory. The legal criterion of fault precludes the recovery of damages for all non-negligent, i.e. "non-fault", accidents both in general and in medical negligence. Despite the allowance of a margin for error (as opposed to negligence[22]), this approach is otherwise apt to be rigid in application, admitting of no intrinsic flexibility in respect of training requirements, inexperience or exhaustion in the medical practitioner. It may be contrasted with the concept of the non-delegable duty, which has been described as a disguised form of vicarious liability.[23] Inasmuch as this implies a broader view of tortious responsibility, it is likely to promote a greater degree of supervision and responsibility on the part of those ultimately liable. It is submitted that this should be implemented in the law of medical negligence by the increased liability of doctors of consultant rank, and in terms of training by the employing board or trust body. It is envisaged that the former issue would be included within the proposals for reform infra, in that such practices would form part of the audit process and would be amenable to scrutiny by the proposed new body, whether ex

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[22]See Lord Edmund-Davies' opinion in Whitehouse v. Jordan, [1981] 1 All E. R. 267, at p. 276: "..while some..errors may be completely consistent with the due exercise of professional skill, other acts or omissions in the course of exercising "clinical judgment" may be so glaringly below proper standards as to make a finding of negligence inevitable."

[23]J.G. Fleming, The Law of Torts, The Law Book Company, seventh edition, 1987, at p. 361.

proprio motu or raised by referral by a patient.

Whilst issues such as hours worked by junior doctors and inexperience may play a part in giving rise to a claim for damages in medical negligence, the wider considerations which they represent generally have no part in the present system of litigation.[24] Some confirmation of undetected negligent, or sub-negligent, defects in the standard of care, may be inferred from the results of the N.C.E.P.O.D. study referred to supra. It must be emphasized that this study is restricted to peri-operative deaths, and therefore excludes (a) non-death adverse outcomes and (b) non-operative deaths. This suggests that those cases included in the study represent a very small proportion of total medical adverse outcomes, in which there presumably must be a significant component of hidden negligence or sub-negligence. In such cases, the recovery of damages is not possible because of a lack of detection or admission. Furthermore, if, as must be possible (and is arguably likely) there is negligent treatment but, coincidentally, no injury or harm occurs,[25] no legal remedy will be

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[24]Cf. Lord Justice Mustill's opinion in Wilsher v. Essex Area Health Authority [1986] 3 All E.R. 801 at p. 812: "..I accept that full allowance must be made for the fact that certain aspects of treatment may have to be carried out in what one witness...called "battle conditions"...[A]n emergency may overburden the available resources, and, if an individual is forced by circumstances to do too many things at once, the fact that he does one of them incorrectly should not lightly be taken as negligence."

[25]Questions as to the circumstances in which damages are awarded have arisen: in Udale v. Bloomsbury Area Health Authority [1983] All E.R. 522, Jupp J. enunciated a principle of

available despite the breach in the standard of care. Although it may be commented that such cases consequently do not matter, it is submitted by the writer that such a response is unsatisfactory and represents a serious inconsistency in failing to discriminate against harm-free episodes of negligence. In doing so, the effect exerted by the law towards the improvement of standards of practice, even if it be at a minimal level of deterrence against negligence, must seriously be impaired as a result. The approach to deterrence is therefore rendered haphazard to the extent that it depends upon the coincidence of negligence, detection, harm and the raising of an action by the patient. Nor is the law likely to be effective in deterring sub-threshhold negligence, i.e. practice which verges upon the legally negligent.

The test for the standard of care, and substantial reliance upon evidence of common practice, will also be argued to be unsatisfactory. This is both in respect of the criterion of comparison (common practice) and the way in which the test operates in different medical settings. This is despite the fact that it has been said that, "[I]n practice, medical negligence is a failure to live up to

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public policy that the birth of a healthy baby did not generally sound in damages following a failed sterilisation, although expenses, and pain and suffering, would do so. However, Thake v. Maurice [1984] 2 All E.R. 513 and Emeh v. Kensington Area Health Authority [1984] 3 All E.R. 1044 disapproved Udale, Emeh involving a congenitally abnormal child. See also McKay v. Essex Area Health Authority 1982 2 W.L.R. 890.

proper medical standards, and those standards are set, not by lawyers, but by doctors".[26] Although it has been argued above that the legal approach to medical negligence is unsystematic, conversely the present legal test may brand a doctor negligent when he or she makes a single error, perhaps occasioned by tiredness or inexperience. Even where an ultimately unsuccessful or unfounded claim is made, a doctor will have been subjected to a stressful period of uncertainty and concern, a factor no doubt partly responsible for the phenomenon of "physician countersuits" against patients for libel or defamation in the United States, where there appears to be considerable dissatisfaction with the law relating to personal injuries.[27] The current approach risks punishing the "innocent", as well as allowing some of the "guilty" to escape unregulated.

Nor is the de facto responsibility of a National Health Service hospital consultant in actual charge of the patient sufficiently reflected legally, as may be seen in reported cases dealing with the negligence of junior doctors, who are sued individually, with their employing health boards and authorities.[28] It is submitted that the

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[26]Medical Negligence, M.A. Jones, cit. sup., at p. 13.

[27]"The pleas for radical reform of personal injury law will not be silenced": D. Harris, Tort Law Reform in the United States, 1991 11 Oxford J. Leg. Studies 407, at p. 407.

[28]Unless in the seemingly rare case of a consultant in charge delegating, appointing or supervising a junior doctor negligently, which would constitute a breach of the consultant's

non-imposition of liability upon those who are actually responsible for junior N.H.S. hospital doctors from day to day, i.e. the senior medical staff, is to ascribe legal responsibility in part wrongly. This may be contrasted with comparable professional activities undertaken in partnerships, whether medical, legal or other, which by reason of their form rather than content, display a different pattern in the ascription of liability and responsibility.[29]

Furthermore, the use of insurance as well as vicarious liability in respect of claims in medical negligence, and the existence of claims which do not proceed to litigation,[30] operate to reduce the effectiveness of the fault, and deterrent, criteria. This effect is reduced further where claims are settled out of court, as amongst the conditions which may be attached may be an obligation to keep the amount paid confidential.

In this context, it is postulated that there exists a public expectation of a very high degree of success in medical care, which is not always justified. It may be that this, allied to what may be described as a consumer or

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(direct) duty of care.

[29]Under the Partnership Act 1890, the firm (and partners) are jointly and severally liable for the delicts of their fellow-partners (section 10; cf. Mair v. Wood 1948 S.C. 83). A firm is generally also vicariously liable for the negligent acts of its employees.

[30]The present author has been unable to determine the number of such claims; this information does not appear to be available.

claims-orientated mentality, may explain at least the perception of an increase in such claims in the United Kingdom in recent years,[31] although the adverse consequences of increasing litigation in this field have been strongly felt in the United States.[32] It may also be suggested that the introduction of Crown indemnity[33] will prove to have the same fault as the preceding medical defence organisation indemnity insurance arrangements - that of being too expensive. The resolution of such conflicting requirements may ultimately call into question the ethos and balance of present treatment and compensation issues.

The criterion of causation, it is submitted, is unsatisfactory in its application to cases of increasing technological and aetiological complexity. Its effect may be to deny the pursuer or plaintiff a remedy, because of an

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[31]Although the quantification of any increase in claims is a matter of great difficulty, it seems accepted that the trend is nevertheless increasing: Medical Negligence, M.A. Jones, cit. sup., at p. 3.

[32]Professional Liability, R.S. Emerson and R.M. Schwartz, 1983 (January) New York State Journal of Medicine 69 at pp. 71 - 74.

[33]Department of Health Circular HC (89) 34. This is not intended to affect the substantive law (although arguably it may exert an effect) but entails that the payment of damages in respect of negligence by N.H.S. hospital doctors, dentists and others whilst acting within their contracts of employment is by the employing health authority. The impetus for this change (from January 1990) was because of the substantial rise in the cost of medical indemnity insurance premiums, which is documented elsewhere. From 1 April 1991, N.H.S. hospitals which have "opted out" and assumed trust status also are held financially responsible for meeting claims in respect of medical negligence arising in the course of their employees' duties.

inability to satisfy the relatively simple, but severe and inflexible, standard required by the law. Indeed, it may pose a conundrum in which even scientific and medical opinion cannot state that a given episode of negligence "caused" the harm in question. Nor, it will be argued, would a reversal of the onus of proof be a satisfactory solution.[34] Other than by excision of the causal criteria by the adoption of a fully needs-based compensation scheme, there appears to be no way of eliding the necessity for some causal enquiry. However, the reform proposals of this thesis seek to soften the strictness of the present regime in both procedural and substantive ways, as considered infra. A slightly wider scope for compensation, administered substantially by doctors, will be suggested in the final chapter, in an attempt to achieve this.

It is therefore thought that there should be a consideration of the aims behind these analytical tools of fault and causation. Principally these number three: firstly, "common sense justice", secondly compensation, and thirdly deterrence. It will be argued that these are in general valid and desirable goals, albeit also requiring, in the writer's view, a shift in emphasis from an entirely reactive system to a partly preventive one.

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[34]Procedural difficulties pertaining to the action for medical negligence, including the recovery of medical records and expert reports, will also be considered where appropriate.

Analysis of these objectives yields interesting results. The content of the rather nebulous term "common sense justice" need not be satisfied solely by the present negligence-based action for medical negligence but may, it is submitted, be better met by other means. The same argument applies to deterrence. Nor, it will be argued, should the present attempt to deliver compensation by the same vehicle as deterrence be continued: separation of the means of attaining these aims, and a re-considered approach to compensation, are required.[35] Against this, however, certain of the arguments advanced by Stapleton[36] must be taken into account. If the suggested reform constitutes a preference in favour of medical negligence victims, it would prima facie fall foul of the argument against preferences in tort[37] or delict. It will be argued that this point is not fully substantiated either in principle or on examination of her arguments and their application to this area.[38] Stapleton concedes ultimately that preference

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[35]In Holland there has for long (since 1967) been a generous system of social security disability benefits which compensates anyone who has lost in excess of 15% of income-earning capacity irrespective of causation. However, in the debate at the time of writing, it has been argued that doctors are insufficiently scrupulous in their assessment of patients, and it seems that the width of the system will require to be restricted: J. Verbeek, 1991 303 B.M.J. at p. 1495.

[36]Disease and the Compensation Debate, J. Stapleton, Oxford University Press, 1986.

[37]Stapleton, op. cit., inter alia at pp. 1-3 and 145 et seq.

[38]Ibid.

is unavoidable, given the principle of scarce resources.[39] Further, in the present context, the point is of doubtful applicability anyway: this is because victims of medical negligence are currently disadvantaged and are therefore analogous to victims of man-made disease in requiring alleviation of this. It would hardly constitute a preference to attempt to restore presently disadvantaged categories to the level of protection to which they are purportedly entitled. Indeed, it is likely that potential medical negligence claims may, as with man-made disease (to which they are not dissimilar) go undetected, an aspect in itself of the disadvantages of medical negligence claims unidentified by the Pearson Commission.[40] Regarding compensation, it will be argued that claimants in respect of medical negligence should be removed from the purview of the law of delict and placed entirely under the auspices of the social security system. Stapleton has argued that systems of compensation should compensate according to the need of the recipient rather than the cause of the disability or other criteria.[41] Whilst such a possibility is desirable on grounds of consistency and rationality, it raises two difficulties. One is that an ultimately

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[39]Stapleton, op. cit., at p. 153: "[T]he most obvious problem with a tort-derived concept of what is a "just" level of benefit is that its costliness may preclude the ultimate comprehensive goal." See also p. 177 et seq.

[40]See Stapleton, op. cit., ch. 2.

[41]Stapleton, op. cit., inter alia at pp. 108 and 112-117.

arbitrary dividing line is still required to distinguish between compensatable and non-compensatable disabilities. If not, there is a risk that compensation would be payable in respect of any imaginable negative aspects of human life, no matter how trivial. The second is that such a widening of the scope of compensation would be likely to constitute, in time if not immediately, an excessive burden on the public purse and that this would necessitate restrictions: "[I]n an ideal world, everyone injured in any accident anywhere, whether caused by negligence or not, would be fully compensated. However, that is not possible."[42] An economically poor nation is highly unlikely to be able to spend the sums on damages (or indeed on its health service) which are paid even at present in the United Kingdom, and it is harder still to imagine the degree of national wealth required to support a massive needs-based scheme. Indeed, the most extensive no-fault accident compensation scheme yet founded, in New Zealand, has encountered difficulties in funding.[43]

However, it is submitted that a compromise between the theoretical appeal of needs-based compensation and the practical constraints of scope and funding is possible. Indeed, it has been recently suggested that reform should

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[42]Should We Find Fault? Stephen Irwin, "Counsel", The Journal of the Bar of England and Wales, April 1991 at p. 18.

[43]Accident Compensation in New Zealand (2 The Current Status), John Cumming, 1992 J.L.S.S. 24; New Zealand: Changes in Accident Compensation, S. Coney, 1992 Lancet 862.

be directed towards eliminating the procedural costs of administering compensation by the tort system whilst recognising that not all injury or disability may be compensated.[44] It will be argued that in view of the present writer's necessarily inexact risk/benefit calculation in relation to medical negligence claims and N.H.S. healthcare, compensation for harm resulting from medical mishap must unavoidably be minimised on grounds of scarce resources, and in any event removed from the sphere of damages, instead being disbursed by the more efficient and less expensive social security mechanism. This is in contrast to the views of most commentators. If it is ultimately impossible rationally to exclude any category of injury or disability from compensation, then logically this requires maximal compensation for <u>all</u> deviations below a notional and global norm.[45] If so, and in the light of the arguments below, it is hardly less logical or rational to reduce compensation as far as possible. If this is correct, it follows that no-fault compensation reforms, usually built upon a delictual-type interpretation of the

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[44]The views of Professor O'Connell, University of Virginia, speaking at a Conference on alternative means of compensating medical accident victims, Oxford, England, April 1992, reported in Reconsidering compensation for medical accidents, R. Smith, 1992 B.M.J. 1066, at p. 1066.

[45]And perhaps requiring a system of fines or contributions levied upon those possessing attributes of whatever sort exceeding this notional norm. The task of identifying and quantifying these seems to the writer to be unworkable and arbitrary.

same aims, are not supported in principle by this thesis. However, the present author seeks to find a middle way between these two polarised possibilities.

The form of compensation proposed would be through the less expensive, quicker and more efficient conduit of the existing social security network. Following from the principle of scarce resources, it is submitted that the amounts of compensation should be kept as low as reasonably possible. For the same reason, an admittedly arbitrary dividing line to exclude trivial injuries, and the early period of disability, would be required. Compensation in respect of medical negligence (and indeed all medical mishap or simply failed treatment) would therefore be outwith the law of negligence, and treated equally with other disabilities. An attempt to reduce public expectation of compensation for adverse medical outcomes might well also be advisable. The equally important non-compensatory goals, including provision for explanations, accountability and deterrence, would be achieved separately and more efficiently by other mechanisms.

These proposals, it is thought, infringe minimally (if at all) Stapleton's caveat against preferences. They are partly the result of a re-evaluation of the balance between the value of the existing health-care delivery mechanism and the role of compensation in relation to its benefits.

It is submitted that the aims underlying the law of medical negligence are better met discretely than by the

unsatisfactory combined delivery mechanism. Hence, a shift of emphasis in the law towards the assessment and even pro-active control of the actual standard of care is required, wholly discretely from the compensation issue. Greater emphasis should be placed upon the concept of deterrence, modified partly to reduce its pejorative connotations. In the criminal law, for example, the law allows for the regulation of conduct per se, not just where demonstrable harm has occurred. This is shown by the modern law of inchoate crimes, including conspiracy theories and particularly the law of attempted crimes. Even if a "strong" theory of criminal attempt is accepted, such as the requirement for an overt act, no harm need accrue to the victim before the perpetrator is liable to criminal legal consequences. Attention should, it is submitted, be devoted to the professional conduct of medical personnel, ideally to minimise and indeed prevent negligent episodes occurring irrespective of the incidence of harm. As is evident in the present law, it is thought that the proposed reforms would not inhibit medical innovation. In effect, peer review as applied to publications, and systems of quality control, would act as arbiter. It is submitted that these suggestions would not be to re-combine the criminal law and the law of delict, but merely to alter the emphasis upon one specific area of the latter. This differs from the approach of most commentators, who tend to

concentrate primarily upon the compensation-related aspects of the law.

The question which remains is how the non-compensatory goals of deterrence, common-sense justice and indeed improvements in the standard of care are to be achieved. It will be argued that various means are required. Amongst these would be a system of reporting, instituted by patients, to a panel analogous in some respects both to the Scottish Mental Welfare Commission, an existing body with a pro-active role in addition to its reactive one, and also similar to the Medical Responsibility Boards in Sweden. The primary reason for this is to ensure that medical negligence, accidents and disappointed patient expectations alike are all considered and an explanation provided; there is some evidence to the effect that this is what most patients seek.[46] In addition it is submitted that such a system would monitor and improve the standard of care, probably at relatively low expense. This system would also require to be supplemented with increased use of medical audit and quality control mechanisms.[47] An enhanced role for the existing General Medical Council in educating and

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[46]A. Simanowitz: No Fault Compensation - Short Term Panacea or Long Term Goal?, in No Fault Compensation in Medicine, ed. R.D. Mann and J.D. Havard, Royal Society of Medicine, 1989, at p. 151.

[47]See chapter entitled "Accountability of Documents" in Clinical Freedom, Sir Raymond Hoffenberg, publ. by The Nuffield Provincial Hospitals Trust, 1987. This is discussed infra in the context of reform.

disciplining persistently negligent doctors is also envisaged. At present it is only the most serious breaches of professional duty which attract its intervention. The emphasis upon an educative and positive reaction to negligent episodes would be increased, instead of a confrontational approach involving maximal stigma. This would take into account the doctor who exercises a high standard of care generally, in order to treat him more justly, rather than to focus solely upon an isolated incident. It is submitted that consideration of cases by the proposed body would be largely inquisitorial in nature rather than adversarial. This, and the separation of compensation from professional accountability would, it is thought, improve communication between doctor and patient.[48] The test for the standard of care would, subject to an appeal to the courts, be applied by the profession itself, reflecting the emphasis presently given to expert evidence, a trend unlikely to change in view of the increasing technology of medical practice. The standard employed would be that of "acceptable practice", tempered with an allowance for greater or lesser experience or qualifications.[49] It would therefore be an objective test tempered with a discretion as to subjective factors. The standard would therefore be seen by doctors, patients and

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[48]A. Simanowitz, ibid.

[49]Discussed infra in the context of reform.

indeed other medical personnel as one which it would be possible to satisfy without the artificial device of over-emphasizing the junior doctor's need to consult his superior. These ideas place greater emphasis upon the benefits, rather than the disadvantages, of a health-care system free of charge at the point of use.

These suggestions are not perceived as a panacea for litigation in medical negligence.[50] It is hoped that they may provide a starting-point for a more effective implementation of essentially the current aims of compensation, deterrence, and indeed prevention of negligence, than is presently achieved. In a wider context, this may be viewed as the next stage in a process of development which has seen the criminal law and the law of reparation separate from one another. To the extent that specialisation, and further refinement of the operation of the law of delict and tort generally, are proposed, it is submitted that the ideas put forward in this thesis may be seen as the next stage of development.

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[50]See, International Medical Malpractice Law, D. Giesen, Mohr/Nijhoff, 1988, at p. 721 et seq., on the trust between the medical and legal professions.

Chapter II

The Historical Overview

This introductory chapter provides a necessarily brief outline of how the case law of medical negligence has developed,[1] in its professional context where appropriate. It is divided into two sections. The first covers principally the period from the early cases of medical negligence, insofar as a starting point is discernible, to the emergence of pre-National Health Service hospital medicine.[2] Whereas the development of the medical profession itself has interacted with that of the law, the establishment of the National Health Service, in Scotland in 1947-48, has had a substantial effect particularly in increasing the scope of vicarious liability and in the duties and standard of care.[3] The second part is not historical, but covers the present bases of liability of

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[1]A full history of this topic is beyond the scope of the present work. For accounts of the historical evolution of the legal systems of Scotland and England, readers are referred respectively inter alia to, A Legal History of Scotland, D. M. Walker, vol. 1 (et seq.), W. Green & Son, 1988 and, A History of English Law, Sir William Holdsworth, vol. 1, Methuen/Sweet and Maxwell, seventh edition, revised 1956 and reprinted 1982.

[2]The transition from the various types of hospital which existed before the establishment of the National Health Service to that system, and the changes in the substantive law which are associated with it, are considered infra in the section entitled the Basis of Liability.

[3]The law after the inception of the National Health Service is essentially the modern law and as such is accorded appropriate treatment infra.

doctors for the delict of negligence. The overall aim of this chapter is to elucidate the development of the common law and to examine its working in the present context.

General Background

It was remarked in 1955 that "[I]t is a tribute to the high standard in general of the medical profession in Scotland that there are practically no decisions on this question [the standard of care] in the reported cases."[4] Indeed Black, in his major historical treatise upon liability for personal injury and death,[5] makes no reference to the occurrence of medical or surgical cases.[6] However, he traces the emergence and development of the remedy of assythment from the prior system, essentially one of tabulated (or tariff) payments in respect of wrongful death

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[4]Per Lord President Clyde in Hunter v. Hanley 1955 S.C. 200 at p. 205. Lord Sorn agreed: "[I]t is curious that there should be no reported case in Scotland in which a decision has been given as to the grounds on which a doctor can be made liable in damages." (ibid., at p. 207).

[5]A Historical Survey of Delictual Liability in Scotland for Personal Injuries and Death, R. Black: the first three parts of this work are published in 1975 VIII C.I.L.S.A. commencing at pages 47, 189 and 318. The final part is published in 1976 IX C.I.L.S.A. at p. 57.

[6]A brief reference is made, albeit not of relevance for the purposes of the present work; part I, ibid. at p. 49.

and injury.[7] Regrettably, Walker's comment upon the twelfth and thirteenth centuries, that

> "[H]arms and wrongs were no doubt common enough in Scotland at this time but there was no law of delict because there could be no enforcement of reparation. Harms were for the most part recognised only if criminally cognisable."[8]

must now be considered dubious in the light of the criticisms made by Sellar.[9] No mention of cases involving medical negligence appears to be made by Walker.[10] The earliest use of the term "negligence" has been stated elsewhere to refer to breach of duty by a public official.[11]

Even at the later time of Stair there is little to suggest that a case in medical negligence might be brought, unless perhaps reflecting something of criminal recklessness or intent.[12] Nevertheless, assythment remained of importance until the late eighteenth or even

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[7]See also, The Development of Reparation, D. M. Walker, 1952 64 Jur. Rev. 101, and A Legal History of Scotland, D. M. Walker, W. Green and Sons, 1988, vol. I, at p. 344, entitled "[O]bligations arising from harms and wrongs".

[8]Walker, A Legal History of Scotland, op. cit., at p. 344.

[9]Review of Walker's A Legal History of Scotland, supra, by W. D. H. Sellar, 1992 10 Law and History Review 188, at p. 193.

[10]Walker, A Legal History of Scotland, op. cit., at p. 344.

[11]This was in the fifteenth century. Chapter 20, Delict and Quasi-Delict, by Hector McKechnie, at p. 266, in An Introduction to Scottish Legal History, Various Authors, publ. The Stair Society, 1958.

[12]McKechnie identifies several tranches of cases concerning professional negligence in the context of debt, and various intentional delicts such as enticement and seduction. Op. cit., at p. 275.

early nineteenth centuries, after which its use declined more steeply, despite continued mis-use of the name.[13] Black considers that this remedy would have been sufficiently flexible to provide compensation for injuries sustained from a defender's "positive acts", perhaps even where accidental.[14]

However, as we have seen, it is doubtful whether the remedy of assythment could have provided a remedy against a medical man in respect of his negligence.[15] The general remedy gave way steadily in favour of the well-documented Roman actio legis Aquiliae[16] and actio injuriarum,[17] a watershed apparently being the unreported case in 1795, documented by McKechnie, of Gardner v. Ferguson.[18] This marked the next stage of a continuing process of separating the legal treatment of criminal matters, i.e. those

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[13]Black, ibid., at pp. 53-54. The existence of this remedy was only brought to an end in 1976, by the Damages (Scotland) Act 1976, c. 13, s. 8: "After the commencement of this Act no person shall in any circumstances have a right to assythment, and accordingly any action claiming the remedy shall (to the extent that it does so) be incompetent."

[14]Black, op. cit., part I, at p. 54.

[15]Assythment would only allow a remedy if the negligence were criminal: McKechnie, op. cit., at p. 274.

[16]See inter alia Part I, Negligence in the Civil Law, F.H. Lawson, Clarendon Press, Oxford, 1950 (reprinted 1962).

[17]See inter alia, Delict and Quasi-Delict, H. McKechnie, ibid.; Designation of Delictual Actions, T. B. Smith, 1972 S.L.T. (News) 125, and Damn Injuria Again, T. B. Smith, 1984 S.L.T. (News) 85.

[18]McKechnie, op. cit. recounts and discusses this case at p. 276.

involving some mental element characterisable as such, from civil litigation, one of the prime functions of which today is to provide compensation.[19] It also marked the appearance of another trend towards the action for damages for medical negligence familiar today. The sum recoverable in the system which ultimately emerged was, unsurprisingly, based upon an assessment of the loss of the claimant.[20] It was a "..reasonable sum by trustworthy men of the court, paying due regard to whether the deceased was bond or free, and the defender shall be answerable for the sum so assessed and shall find sufficient cautioners...therefor."[21] The profession of medicine experienced many changes since the time of Hippocrates, who suggested some characteristics of a good surgeon.[22] These included the following:

> "[T]he finger nails neither to exceed nor to come short of the finger tips. Good formation of the fingers, thumb well opposed to forefinger. Practice at all operations with each hand and

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[19]This is to over-simplify. The other aims of the law of delict, such as enforcing moral responsibility and deterrence, will be considered inter alia in the context of the moral basis of fault.

[20]For an account of legal developments reflecting the change from pastoral to arable farming and feudalism, see chapter VI, Part III (The Age of Transition), J. W. Jeudwine, Tort, Crime and Police in Mediaeval Britain, Williams and Norgate, London, 1917, especially pp. 88-96.

[21]Black, ibid., at pp. 52-53.

[22]Hippocrates lived in the fifth century B.C. The Hippocratic Oath is now taken by few, if any, doctors: Pathways in Medical Ethics, Alan G. Johnson, Edward Arnold, 1990, at p. 12. In fact the practice of the Greek doctors of the Hippocratic era appears not to have been all with this ideal in mind (Johnson, op. cit., at p. 16).

> with both together. Arrange the boiled water, the light, the instruments, the position of the assistants. Promote ability, speed, painlessness, elegance and readiness."[23]

Hamilton has chronicled some of the development of the Scottish profession thus:

> "[D]uring James IV's peaceful reign, Scotland was a leader in the early European renaissance and under this enlightened King, the study of medicine in Scotland was particularly favoured and the growth of a separate secular profession encouraged. Medical practice outside monasteries developed, and the surgeons in Edinburgh were first to appear as a corporate body."[24]

It appears that the partial antecedent of the present medical profession, unlike the clergy, another ancient profession, was the trade guild.[25] These have been seen as the forerunners of the partly-regulatory bodies existing today such as the General Medical Council.[26] It is likely that these bodies played a significant role in the maintenance of standards of practice, as well as other aims:

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[23]Recounted by Sir Charles Illingworth, in "The Sanguine Mystery; This Bloody and Butcherly Department of the Healing Art", The Nuffield Provincial Hospitals Trust, 1970, at p. 11. These qualities had perhaps partly been forgotten during the early middle ages.

[24]The Healers, A History of Medicine in Scotland, D. Hamilton, Canongate, Edinburgh, 1987, at p. 7.

[25]An Introduction to the Law Relating to the Health Care Professions, P. F. C. Bayliss, Ravenswood Publications, 1987, at p. 1. Bayliss states that the guilds for the city of London appeared at the turn of the first millenium.

[26]Bayliss, op. cit., at p. 1.

> "The main privileges of each guild were to enjoy a monopoly over its particular trade in the city, to hold property and to exercise a power of discipline or punishment over its members, and over non-members who infringed its rights. The guilds controlled entry to their trades by use of apprenticeships, and they guarded their trade secrets closely....[M]any of the principles of the guilds will be found in the modern day legislation which controls the health care professions. There is an attempt to delineate each profession from another, to regulate admission to it by means of a common standard of training, to exercise a disciplinary power over its members in their professional practice and to punish unauthorised practice."[27]

Such medical practice as existed from around the time of the eleventh century was regulated by guilds of "medicine, surgery and dentistry";[28] the practice of medicine had subdivided relatively early into these fundamental divisions, still extant today.[29] To describe surgery as thus regulated is perhaps to endow it with an aura of respectability not always justified. That there existed considerable dubious practice seems likely, even judged by the early standards then prevailing:

> "[S]urgery was not respectable; moreover its practice, and that of "practical" medicine in

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[27]Bayliss, op. cit., at pp. 1-2. The emphasis is added. No doubt this analysis may equally be applied to other professions, such as the legal profession.

[28]Bayliss, op. cit., at p. 2.

[29]Today's familiar subspecialties were much longer in their gestation. The development of ophthalmology, for example, is cognisable by the substantial numbers of specialist textbooks published in England during the late eighteenth and early nineteenth centuries: A Brief History of Ophthalmic Publications in America, D. M. Albert, 1986 93 Ophthalmology 699 at p. 701.

> general, was largely in the hands of barber-surgeons, leeches and other practitioners of folk-remedies, and similarly unlettered persons with no grounding in the arts or any license to practice from an established school of medicine."[30]

These barber-surgeons of the middle ages apparently tended to practise in the towns, unlike their physician counterparts, who practised in the country.[31]

It is interesting to note the influence of guild-like bodies in the development of English law during this period, analogous to that, for example, of the common serjeants, viz.: "[T]he order of the coif was a guild of countors (sic)....though it did not follow the craft guilds by seeking incorporation or civic powers."[32] The guilds' "..responsibility included both the prototypes for ethical practice and the grievance, mediation, and punishment procedures against malpractices...[M]edieval (sic) London's medical guilds regulated professional conduct ranging from

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[30]"The Mediaeval Traffic with Europe", by J. D. Galbraith, in The Influence of Scottish Medicine, ed. D. Dow (The Proceedings of the 11th British Congress on the History of Medicine, Edinburgh, 1986); Parthenon, 1988, at p. 11. Galbraith, ibid., states that clerics were, in 1215, prohibited by decree from the practice of surgery. (This was by decree of Pope Innocent III: see "The Sanguine Mystery; This Bloody and Butcherly Department of the Healing Art", by Sir Charles Illingworth, The Nuffield Provincial Hospitals Trust, 1970, at p. 1.) However, non-surgical physicians, Galbraith says, were more respected as an academic discipline, and taught during that period at universities.

[31]The Healers, A History of Medicine in Scotland, D. Hamilton, supra, at p. 21.

[32]The Order of Serjeants at Law, J. H. Baker, publ. Selden Society, (Supplementary Series, vol. 5), London, 1984, at p. 20.

treatment of wounds and diseases through minutiae of behaviour at guild meetings."[33]

In the practice of medicine, however, the clergy now obtained the ascendancy rather than surgeons. Thus they

> "...so established the distinction between priestly physicians and profane surgeons, between a cultivated exercise and a crude craft, between the sombre profession of medicine and the sanguine mystery of surgery...[B]ut although thus relegated to inferior status, surgery could at least claim priority in date of origin, for long before the dawn of history the surgical treatment of wounds must have been undertaken; even earlier than the psychiatric administrations of the witch doctor and certainly many millenium (sic) before the advent of rational medicine."[34]

However, it is likely that this connection between the practice of medicine and the Church[35] continued until the Renaissance and intellectual revolution originating in the seventeenth century.[36] During this period, advancement in medicine seems scant by modern standards, but nevertheless contained a core of rationality.[37] This is demonstrated for example by surgeon Tagliacozzi's understanding of the

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[33]Medical Malpractice and Peer Review in Medieval (sic) England, M. P. Cosman, 1975 80 Transactions of the American Academy of Ophthalmology and Otolaryngology 293, at pp. 293 - 294.

[34]"The Sanguine Mystery, This Bloody and Butcherly Department of the Healing Art", by Sir Charles Illingworth, op. cit., at p. 1.

[35]See, The Healers, A History of Medicine in Scotland, D. Hamilton, supra, at p. 21 et seq.

[36]Johnson, op. cit., at pp. 15-16.

[37]Bayliss, op. cit., at p. 2.

techniques of rhinoplasty, and the importance of beneficial patient diet in recovery from surgery.[38]

By contrast, however, far greater, and more rapid, development was evident from approximately 1600 onwards.[39] It is interesting to note that this formative period coincides with the major legal scholarship of the Scottish institutional writers, in particular the writing of Viscount Stair's Institutions of the Law of Scotland, published in 1681. In the 17th century in Scotland, however, competition became evident between the emerging groupings of physicians and apothecaries.[40] Hamilton identifies and describes it thus:

> "[T]his [the apothecaries' increasing importance] was in spite of their lowly place in the town's hierarchy: unlike the surgeons, they did not have a craft guild. Relations between the physicians and the apothecaries were not cordial and the tension between the two groups became important in medical politics in Edinburgh as it did also in London. The reason was simple. The physician's code did not allow them to make up their own medicines or lower their considerable fees. As the apothecary's skills and knowledge increased as a result of the physicians (sic) complex prescriptions, the patients started to consult directly with an apothecary and were

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[38]Surgical Malpractice in the Renaissance and Today, Madeleine Cosman, 1990 86 Plastic and Reconstructive Surgery 1017 at pp. 1020 - 1022.

[39]Bayliss, op. cit., at p. 2. Johnson, op. cit., referring generally to the Reformation, comments at p. 16 that "[T]he turmoil in the basis of ethics coincided with the founding of modern medicine. For example, anaesthesia and antiseptics were both discovered within a few years of the publication of Darwin's On the origin of Species (1859)."

[40]The Healers, A History of Medicine in Scotland, D. Hamilton, supra, at p. 57.

> treated by them. This was a constant source of outrage to the physicians."[41]

For the emergence of the structured and highly disciplined profession of medicine today, we must look to the nineteenth century and its advances in public health.[42] The Medical Act of 1858 provides the basic structure of the profession which is still in evidence today;[43] the General Medical Council, and a system of registration for doctors. A primary function of this professional body was, and is, to oversee and regulate doctors' qualification and training.[44]

At the time of the inception of this body, another trend was beginning to make itself felt - the emergence of the medical defence bodies, one of the earliest to be established being the Medical Defence Union, a registered company limited by guarantee and founded in October 1885. This was following professional concern generated inter alia by a damages action for negligent treatment and a criminal prosecution for assault, involving a different

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[41]The Healers, A History of Medicine in Scotland, D. Hamilton, supra, at p. 57.

[42]Bayliss, op. cit., at p. 2.

[43]Currently the Medical Act of 1983.

[44]An account of the role of the General Medical Council, and the statutory organisation of the profession, may be found in Bayliss, op. cit., part I and ch. 7 of Part II. For an account of the establishment of the National Health Service in Scotland, see, The Healers, A History of Medicine in Scotland, D. Hamilton, supra, at p. 258 et seq.

practitioner, in the preceding few years.[45] However, the Medical Defence Association, which sought to prosecute unregistered doctors and to support those registered but in medico-legal difficulty, pre-dated the Medical Defence Union by roughly a decade but, after the latter's establishment, ultimately became defunct.[46] Parallel American recognition of the emerging trend of malpractice claims is demonstrated by the appearance in New York of journal articles in 1822, and of a conference speech in 1872, commenting upon and covering the subject.[47]

The medical defence societies now number three in the United Kingdom,[48] and their main function is to protect, advise, defend and indemnify doctors against professional negligence claims.[49]

Although there was sufficient litigation, both criminal and civil, to prompt the founding of a defence

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[45]Sixty Years of Medical Defence, Robert Forbes, publ. The Medical Defence Union Ltd., 1948, at pp. 2-3.

[46]Forbes, op. cit., at pp. 4-5.

[47]The History of Medical Malpractice in New York State, S. Cirincione, 1986 (July) New York State Journal of Medicine 361, at p. 362.

[48]The other two being the Medical Protection Society, based in London, and the Medical and Dental Defence Union of Scotland, whose headquarters at the time of writing is in Glasgow.

[49]At the time of writing, the Crown indemnity scheme for doctors had only recently been introduced, and the effects of it upon the defence bodies still remain to be clarified, as does the possibility that commercial insurance companies might, if they succeed in obtaining sufficient past claims data, also compete in this area.

union in 1885, remarkably little of this has found its way into the law reports until this century and the last, perhaps because "[O]mission and neglect are too intangible for the mediaeval mind."[50] The earliest reference to the law of medical malpractice which the author has been able to trace is to the fourteenth century law in England: "[T]he basic law of malpractice was largely complete by the end of the fourteenth century; in effect, it required the physician to be diligent to avoid negligence and to do all he could for his patient. He was not required to effect a cure or to possess extraordinary powers or skills."[51]

It has been suggested that recognition that the healing professions, including the veterinary profession (which was of greater importance in pre-mechanised days) could not be relied upon to provide a cure, followed the outbreak of the plague during this period. In the sixteenth and seventeenth centuries, developments in knowledge and the practice of medicine were accompanied by an increase in the control over those who were permitted to

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[50]Potter's Historical Introduction to English Law and its Institutions, fourth edition, by A K. R. Kiralfy, Sweet and Maxwell, 1962, at p. 255. However, the surgeon's "common calling" has been said to give rise to liability independent of contract but based upon the proper exercise of the art. See, for example, Medical Negligence, Lord Nathan, Butterworths, London, 1957, ch. 2, at p. 6.

[51]Professional Liability, R. S. Emerson and R. M. Schwartz, 1983 (January) New York State Journal of Medicine 69, at p. 69.

hold themselves out as practitioners.[52]

However, it was not until these, and later, centuries that the development of the medical profession, and attendant claims in respect of malpractice brought a systematic consideration of the essential basis of the action[53] and of the test for breach of the standard of care.[54] One of the earliest of these cases is considered by Nathan: Everard v. Hopkins,[55] reported in 1615 to the effect that a negligently injured patient may sue a doctor who is in contract with a third party. Reported cases were sporadic after this,[56] and it is generally the nineteenth century which furnishes us with more material.[57]

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[52]Professional Liability, R. S. Emerson and R. M. Schwartz, op. cit., at p. 70.

[53]For example, where a husband employed a doctor to attend to his wife. If she then suffered injury resulting from negligent treatment and the husband sued, the doctor could seek to argue that there was no title to sue, because of the doctrine of privity of contract. This in fact happened in the Scottish case of Edgar v. Lamont 1914 S.C. 277. (The doctor's argument was rejected, with liability being based upon a duty owed to a non-contracting patient. The writer is not aware of any attempt's being made to found an action raised by wife in respect of a jus quaesitum tertio.)

[54]Nathan states that the delictual (sic) remedy of assumpsit came to be associated with some cases of medical negligence brought under contract (op. cit., at p. 6). Confusion was thus engendered as, at least in some of the early (English) cases, there was a tendency to express tortious liability in contractual language (Nathan, op. cit., at pp. 6-7).

[55]Cited as (1615) 2 Bulst. 332 by Nathan, op. cit., at p. 9.

[56]E.g. Slater v. Baker and Stapleton (1767) 2 Wils. K. B. 359.

[57]Slater v. Baker and Stapleton, (1767) 2 Wils. K. B. 359, is an English case tried, as were almost all, by jury. The plaintiff was the patient. Primarily the report recounts the

The writer submits that the substantive law of medical negligence has changed less than one might expect since this period. The difference is principally in the test for the standard of care and in the use of juries. The English case of Seare v. Prentice,[58] reported in 1807, provides some support for this. No question of privity of contract was raised, the plaintiff shoemaker also being the patient in respect of a dislocated elbow and fractured arm which prevented him from carrying on his trade. In issue was whether the doctor had been negligent, a verdict in his favour having been returned at the original trial. It may be noted that, as this was prior to the passing of the Medical Act 1858, the doctor had not only held himself out as a surgeon, but was clearly also qualified and experienced to a generally appropriate degree; no issue of his being an impostor was raised. As is still the case, the evidence of expert medical witnesses was of great influence, Lord Ellenborough C.J. holding the general rule to be that "..an ordinary degree of skill is necessary for a surgeon who undertakes to perform surgical operations....and although I am ready to admit that a surgeon would be liable for crassa ignorantia,...,without

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differing expert (and other) evidence upon the conduct of the doctor and apothecary in question; very little discussion of the legal standard is given. Two legal issues raised were a possible contractual relationship between co-defendants, and of more interest, a very brief reference to the question of consent and trespass "vi et armis".

[58]1807 8 East. 348.

the ordinary qualification of skill...".[59] The merits were dealt with unanimously, Lord Ellenborough C.J. continuing "...yet the [above] question did not arise upon the evidence; for no want of skill was imputed to the defendant; and therefore the opinion of the learned Judge [Heath J. at first instance] upon the point does not affect the merits of the verdict upon the evidence in the cause."[60] An immediate difference between this and the modern standard of care is in the reference to "crassa ignorantia". Today, as discussed infra, the standard is one of the ordinary skilled doctor.[61] It is also clear that there is only one standard to be applied, that of negligence and not, as is perhaps implied in Seare, an additional alternative one of gross negligence. The writer further suggests that in the present law, ignorance and want of skill, rather than involving forensic investigation under a separate heading as in Seare, would simply be incorporated within the concept of negligence.

The question of whether a non-contracting patient could sue a surgeon arose, by reason of infelicitous pleadings, in the English case of Pippin v. Shepherd in 1822.[62] Counsel for the defendant (Bayly) summed up the

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[59]Seare v. Prentice, ibid., at p. 352.

[60]Seare v. Prentice, ibid., also at p. 352.

[61]See Farquhar v. Murray 1901 3 F. 859 and Hunter v. Hanley 1955 S.C. 200, discussed infra.

[62]1822 11 Price 400.

matter thus: "[T]he single question is, whether this declaration, which is for a tort in form, but founded, in substance, on a contract, can be considered sufficient, when it does not state any one of the terms of the contract, which is the gist of the plaintiff's cause of action."[63] There was no averment of a contract, but bald statements that the defendant was a surgeon and had been employed to produce a cure, in which he had (negligently) failed. The three judges present[64] agreed that the patient could bring an action, apparently based upon the tort doctrine of assumpsit, irrespective of the contracting party.[65] An interesting insight into the context of treatment at that time and a related policy question may be gleaned from the opinion of Garrow B.:

> "[I]n the practice of surgery particularly, the public are exposed to great risks from the number of ignorant persons professing a knowledge of the art without the least pretensions to the necessary qualifications, and they often inflict very serious injury on those who are so unfortunate as to fall into their hands. To hold

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[63]Pippin v. Shepherd, supra, at p. 407.

[64]Lord Richards C.B., Graham B. and Garrow B.; Wood B. being absent.

[65]Suggesting that gratuitous treatment would, if negligent, be afforded the same remedy. (See generally the opinion of Heath J. in Shiells and Thorne v. Blackburne (1789) 1 Hy. Bl. 158 and Coggs v. Bernard (1703) Ld. Raym. 909. In relation to the former case, see also Nathan, op. cit., at p. 8 (footnote), who suggests that, following Lord Loughborough's opinion, the true position is "..that where the services are rendered by one professing special skill there exists a duty to exercise skill as well as care.")

> the contrary would be to leave such persons in a remedyless state."[66]

Gladwell v. Steggall,[67] involving a declaration apparently based upon tort, concerned an infant of ten years whose father employed a clergyman who held himself out as having medical skills, to cure a leg condition albeit with unfortunate results. It was held that the patient was entitled to raise an action in respect of this through her "next friend", the action being acknowledged by the judges to be delictually based.[68] Whilst in 1835 the case of Hancke v. Hooper[69] gave authority for the proposition that

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[66]Pippin v. Shepherd, supra, per Garrow B., at p. 409.

[67]1839 5 Bing. (N.C.) 734.

[68]Charlesworth and Percy (on Negligence, by R.A. Percy, Sweet and Maxwell, seventh edition, 1983 at p. 542), discussing consideration in contract, citing inter alia Gladwell v. Steggall (supra) as authority, say that "[T]his consent, which may be implied, amounts to an agreement on the part of the patient to allow himself to be treated and is sufficient consideration for an implied promise to exercise proper care and skill.". Whilst this is highly probable, the writer confesses to puzzlement as to the authority in Gladwell for this proposition; it is respectfully submitted that the case exemplifies this analysis by implication. See also Harmer v. Cornelius (1858) 5 C.B. (N.S.) 236.

[69]1835 7 Car. & P. 81. Tindall C.J. in his summing up to the jury, ibid. at p. 84, said "..the question is, whether you think the injury which the plaintiff has sustained is attributable to a want of proper skill on the part of the young man, or to some accident. A surgeon does not become an actual insurer; he is only bound to display sufficient skill and knowledge of his profession. If from some accident, or variation in the frame of a particular individual, an injury happens, it is not a fault in the medical man."

a surgeon was (vicariously) liable[70] for the negligent act of his apprentice,[71] the best known case of this period, dealing with the standard of care, was Lanphier (and Wife) v. Phipos.[72] Mrs Lanphier, alarmed at an encounter with a cow in a field, tripped and apparently broke a bone in her arm. However, treatment by splint and bathing in warm water did not prevent serious swelling and inflammation. In charging the jury after reading out the pleadings, Lord Chief Justice Tindal, in a classic statement, said,

> "[W]hat you will have to say is this, whether you are satisfied that the injury sustained is attributable to the want of a reasonable and proper degree of care and skill in the defendant's treatment. Every person who enters into a learned profession undertakes to bring to it the exercise of it a reasonable degree of care and skill. He does not undertake, if he is an attorney, that at all events you shall gain your case, nor does a surgeon undertake that he will perform a cure; nor does he undertake to use the highest possible degree of skill. There may be persons who have higher education and greater advantages than he has, but he undertakes to bring a fair, reasonable and competent degree of skill..."[73]

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[70]But a surgeon would not be liable for the carrying out of something properly left to another person, such as a nurse bathing a patient: Perionowsky v. Freeman (1866) 4 F. & F. 977.

[71]Many of these cases disclose that the medical practice concerned was, by modern standards, primitive. The treatment sought by the patient in this case was bleeding for a head ailment. However, since the patient specifically had requested this treatment, having obtained relief from it on a previous occasion, the surgeon could not be held liable for the carrying out of the patient's wishes not providing a beneficial result.

[72]1838 8 Car. & P. 475.

[73]Lanphier v. Phipos 1838 8 Car. & P. 475, per Tindal C.J. at p. 479.

Dugdale and Stanton comment that the framing of the test in this manner was to emphasize to the jury that the professional man was not to be taken as warranting the success of his work;[74] the implications of this were fully drawn out in Lord Donaldson's speech regarding the possibility of non-negligent errors of medical judgment in the House of Lords in Whitehouse v. Jordan[75] as recently as 1981. It is notable that, in relation to an attorney, it was held in 1836 that a mistake would only ground an action for damages for negligence if it also demonstrated want of reasonable skill and care.[76] This approach was in essence confirmed subsequently in Rich v. Pierpont,[77] an obstetric case in which Erle C.J. said "[A] medical man was certainly not answerable merely because some other practitioner might possibly have shown greater skill and knowledge; but he was bound to have that degree of skill which could not be defined but which, in the opinion of the jury, was a

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[74]Professional Negligence, A.M. Dugdale and K.M. Stanton, second edition, Butterworths, 1989, at pp. 232-233. They also comment (ibid.) that "[I]t is doubtful whether its use produced decisions which would differ from modern law." The writer respectfully agrees with this view; discusssed infra.

[75][1981] 1 W.L.R. 246.

[76]Per Alderson B., at pp. 292-293 in Shilcock v. Passman, 1836 7 Car. & P. 289.

[77]1862 3 F. & F. 35.

competent degree of skill and knowledge."[78] This test was invoked by the defendant's holding himself out as a doctor;[79] this avoided difficulties, in those early days of registration of qualified doctors, in rendering impostors liable under the same system which also dealt with the negligence of those who were duly qualified. Nor was the possibility of criminal liability for negligence unknown. Thus in Reg. v. Chamberlain,[80] a herbalist prescribed arsenical ointment for a patient suffering from a tumour. The patient, not advised of the potent and toxic nature of the ointment, died. Although a verdict of not guilty of manslaughter was returned, the terms of Blackburn J.'s charge to the jury are notable for their expression of the standard of care:

> "[I]f the prisoner by culpable negligence had caused the death of the deceased woman, he was guilty of manslaughter; but the mere fact that death had occurred through mistake or misfortune would not be enough, or no medical man would be safe. There must, however, be competent knowledge and care in dealing with a dangerous drug, and if the man either was ignorant of the nature of the drug he used, or was guilty of gross want of care in its use, there would be criminal culpability."[81]

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[78]Rich v, Pierpont, supra, per Erle C.J. at p. 40. The jury found for the defendant doctor. One might observe that, if civil trial by jury was presumably supposed to be by the defendant's peers, there is an argument that the jury should consist of doctors!

[79]Jones v. Fay 1865 4 F. & F. 525; Ruddock v. Lowe 1865 4 F. & F. 519.

[80]1864 10 Cox's Crim. C. 486.

[81]Reg. v. Chamberlain, ibid., per Blackburn J. at p. 487.

Little explanation of the term "culpable negligence" is given. The word "culpable" presumably signifies a greater degree of negligence than on the civil standard, and thus seems to be more analogous to today's criminal recklessness. The use of the words "gross want of care" offers some support for this proposition. However, it is possible that the prosecution was inspired by the serious consequences of the malpractice rather than the demonstrated seriousness of the mental element. In a similar case, Reg v. McLeod[82] in 1874, Denman J. charged the jury that,

> "..if the jury were satisfied that the death was caused by morphia; and if it was administered without proper care, skill and caution, and without a proper knowledge of morphia by the prisoner...in any other way that would be clear negligence - he would not use the term "gross negligence", because it was liable to misinterpretation - and if that was so the prisoner would be guilty of manslaughter."[83]

This also suggests that something similar to the civil standard of negligence, in suspicious or tragic circumstances, would have been in theory sufficient to ground conviction for manslaughter.[84] It again suggests

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[82]1874 12 Cox's Crim. C. 534.

[83]Reg. v. McLeod, ibid., per Denman J. at p. 538.

[84]Again a verdict of not guilty was returned.

that there was an overlap in the civil and criminal approaches to medical negligence during this period in England.

The Scottish Approach

By contrast, it seems that in Scotland very few, if any, cases of medical negligence had been reported during this period,[85] despite the increasing medical consultations suggested by the founding of the Royal Medical Colleges of Scotland.[86] Thus Guthrie Smith commented in 1889[87] that,

> "[T]he cases in which damages have been claimed for negligence from medical men are not very numerous, and the few that have occurred have chiefly arisen from hasty and inaccurate expressions of opinion in medico-legal cases.... [F]or illegal detention in a lunatic asylum damages may be recovered from the person applying for the warrant, the medical men who grant the certificate, and the keepers of the asylum who

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[85]Remarkably little reference to such cases, in law reports, digests, Institutional writings and textbooks has been found by the writer, in research in various University and the National Libraries, etc.

[86]The Royal College of Surgeons of Edinburgh, founded 1505; The Royal College of Physicians and Surgeons of Glasgow, founded 1599 and the Royal College of Physicians of Edinburgh, founded 1681. Source: chapter 12: The Scottish Colleges - Teaching and Examining Abroad, T. J. Thomson, p. 161, in The Influence of Scottish Medicine, ed. D. Dow, Parthenon, 1988 (The Proceedings of the 11th British Congress on the History of Medicine, organised by the Scottish Society of the History of Medicine, Edinburgh, August 1986.)

[87]The Law of Damages, J. Guthrie Smith, second edition, 1889, T. & T. Clark, at pp. 54-55. See also first edition, 1864.

> joined in the conspiracy, but under our reformed lunacy law such a case can hardly now occur...."[88]

The learned author continues, following a subheading, "[T]he option of suing the delinquent in contract or delict, which is competent against legal practitioners as well as medical men..."[89] Although this appears to be a general statement, it is not clear whether the reference to medical men is restricted to the context of certification under the then-prevailing lunacy laws.[90]

A similar case is that of Urquhart v. Grigor[91] in 1864, albeit involving a doctor's making an incorrect statement regarding the pursuer to a third party, a procurator fiscal.[92] If given honestly, it was held, the doctor was not held responsible for the statement's correctness.[93] However, Simpson v. Allan[94] exemplifies the type of medical

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[88]Guthrie Smith, op. cit., at p. 54. Footnotes are omitted.

[89]Guthrie Smith, op. cit., at p. 55. The emphasis is added.

[90]Given the dearth of authority on this subject to which Guthrie Smith previously refers (ibid., at p. 54) it seems likely that some such restriction upon its meaning, notwithstanding the context, may not unreasonably be inferred.

[91]1864 3 M. 283.

[92]The headnote refers to "[I]njury affecting character" and "[P]rivileged statement".

[93]In England, it was ultimately held that a doctor who examined a patient pursuant to the Lunacy and Mental Treatment Acts 1890-1930, and negligently and wrongly certified him as insane, owed the patient a duty of care; see inter alia Hall v. Semple 1862 3 F. & F. 337 and Harnett v. Fisher [1927] 1 K.B. 402.

[94]1893 1 S.L.T. 526.

malpractice case of which the Scottish courts were seized at that time.[95] Although very little detail is reported, the essence of the dispute was that the fact of the defender's employment as a "medical attendant" was in issue. The basis of liability, if duly established, would thus have been in contract. The question of law, although not its answer, is recorded as whether the defender "through negligence or unskilfulness, failed to supply proper medical and surgical treatment to the pursuer."[96] An oft-cited early case is that of Farquhar v. Murray[97] in 1901. The case provides notably little assistance in that it concentrates upon the pleadings and the evidence at the expense of considering the law itself, despite the fact that Lord Young stated that "[I]n my somewhat long experience I cannot remember having seen a similar case before."[98] However, the standard of care envisaged by the court was that of gross negligence:

> "I understand the law to be this, that an action of damages may be maintained against a medical man,...,for crassa ignorantia or crassa negligentia. But there must be either gross ignorance or gross negligence, and this action in order to be relevant must present a case of gross

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[95]See also Smith v. McLachlan 1894 S.L.T. (Reps.) 526.

[96]Ibid., at p. 527.

[97]1901 3 F. 859. The case of Pollok (sic) 1900 2 F. 354, regarding an unauthorised post mortem examination, is unhelpful to our purposes.

[98]Farquhar v. Murray, at p. 862.

> ignorance, gross want of professional knowledge, or gross carelessness."[99]

Lord Moncreiff agreed both that the pursuer had a prima facie case and as to the standard of care:

> "I agree with the majority of your Lordships that on the pursuer's statements there was a case for inquiry. I do not doubt that in some circumstances a medical man may render himself liable in damages if through gross negligence or remissness (sic) he induces or permits a patient to continue under a course of treatment which, though beneficial at first, becomes injurious and dangerous if continued too long."[100]

Despite these expressions as to the standard, and the argument by the defender that the word "gross" should be included in the question at issue, it was referred to the jury without the amendment sought.[101] Nevertheless, it is submitted that the case bespeaks a test of gross negligence.

With this standard of care seemingly accepted, other developments proceeded apace in the Scots law, some of which reflected those in England. Thus, liability may likewise be based upon holding out.[102] The question of whether a patient had title to sue, where her husband

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[99]Per Lord Young, ibid., at p. 862. His Lordship would have upheld the Lord Ordinary's judgment.

[100]Farquhar v. Murray, ibid., per Lord Moncrieff, at p. 864.

[101]Farquhar v. Murray, ibid., at p. 864.

[102]Dickson v. Hygienic Institute 1910 S.C. 352.

contracted with the doctor to treat his wife,[103] was also answered in the affirmative. Lord Salvesen said:

> "..the clear ground of action is that a doctor owes a duty to the patient, whoever has called him in and whoever is liable for his bill, and it is for breach of that duty that he is liable, in other words, that it is for negligence arising in the course of the employment, and not in respect of the breach of contract with the employer."[104]

Again as south of the border, the liability was recognised as being based upon the holding out of the practitioner concerned.[105]

An additional development in medical practice became reflected in the case-law. Whereas hitherto most litigation had been concerned with individual practitioners, increases in the size of general practices, and increases in the amount of hospital medical practice,[106] inevitably gave rise to claims. The introduction of indemnity insurance for doctors, and the passing of the

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[103]This arose in Edgar v. Lamont 1914 S.C. 277. The wife's originally cut finger ultimately required amputation.

[104]Edgar v. Lamont, ibid., per Lord Salvesen at pp. 279-280.

[105]Dixon v. Hygienic Institute 1910 S.C. 352.

[106]Arguably also the advances in anaesthetics, away from ether to curare-derived skeletal muscle-relaxant drugs, such as succinylcholine, which allowed surgery to become much safer.

National Health Insurance Act 1911,[107] have been advanced as further factors affecting the accelerated development and expansion of the services of the Medical Defence Union.[108] Perhaps the most obvious expression of this was the establishment of reciprocal medical defence agreements, recognising the doctrine of vicarious liability applying to partnerships. These extended protection and indemnity for doctors practising as principals in general practice, to employed assistants or locum tenens, even if members of a different medical protection organisation.[109]

The hospital facilities that existed in England up until approximately 1800 had consisted mainly of (charitable) voluntary hospitals and workhouses;[110] perhaps low expectations, both generally and in respect of the likely efficacy of treatment, together with lack of resources with which to pursue a claim, militated against many being brought. In Scotland, the Royal College of

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[107]Raising the question whether doctors were actually employees, under a contract of service with the hospital or not: see Scottish Insurance Commissioners v. Edinburgh Royal Infirmary 1913 S.C. 751.

[108]Sixty Years of Medical Defence, Robert Forbes, ibid., at p. 59. One reason apparently put forward for the need for the indemnity scheme was the " "greatly increased danger of fictitious claims being made owing to the spirit fostered by the Workmen's Compensation Act of 1906 among the wage-earning classes." " (ibid., at p. 59.)

[109]Such as the then London and Counties Medical Protection Society. See Forbes, op. cit., at pp. 66-67.

[110]The Hospitals 1800-1948: A Study in Social Administration in England and Wales, Brian Abel-Smith and Robert Pinker, Heinemann, London, 1964, at p. 4.

Physicians of Edinburgh had in 1725 established an appeal for the building of an Infirmary.[111] Indeed, pre-eminent amongst the various types of pre-N.H.S. hospitals were voluntary (charitably or voluntarily endowed), and local or public authority, hospitals,[112] the transfer of most of which to the health service took place in the 1940s. One of the main legal issues which this process raised, or expanded, was that of vicarious liability.

This, already known in Scots law,[113] did not take long to become as firmly established in the law of medical negligence as elsewhere, even before the roles of medical personnel and their status as employees or independent contractors had been clarified,[114] ultimately by absorption

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[111]The Hospital Movement of the Eighteenth Century and its Development, W. H. McMenemy, at p. 56, ch. 3 in The Evolution of Hospitals in Britain, ed. F.N.L. Poynter, Pitman, London, 1964.

[112]Law Relating to Hospitals and Kindred Institutions, S. R. Speller, third edition, 1956, Lewis & Co., at pp. 1-3, and chapter 1, generally on the definition and classification of hospitals.

[113]See Baird v. Hamilton (1826) 4 S. 790. A discussion of the development of the principle is outwith the scope of this work; much has been written on the subject. See, principally, the discussions in D. M. Walker, The Development of Reparation, 1952 J. R. 101; Culpa Tenet Suos Auctores: The Application of a Principle, G. MacCormack, 1974 J. R. 83.

[114]See inter alia Hillyer v. Governors of St. Bartholomew's Hospital [1909] 2 K.B. 820, Gold v. Essex County Council [1942] 2 K.B. 293, Cassidy v. Ministry of Health [1951] 2 K.B. 343, Reidford v. Magistrates of Aberdeen, 1933 S.C. 276, and McDonald v. Board of Management of Glasgow and Western Hospitals 1954 S.C. 453, discussed infra. An account of the development of hospital liability (in England) for professional staff is given by R. M. Jackson and J. L. Powell, in Professional Negligence, third edition, Sweet and Maxwell, 1992, at p. 458 et seq.

into the National Health Service.[115] In modern practice, it is based upon the employment of medical personnel, at least so far as N.H.S. hospitals are concerned. In the private health-care sector, many medical personnel, such as radiologists and nursing staff, will be subject to a contract of employment with the hospital or private healthcare company, and as such, the normal principles of vicarious liability will apply. Where doctors, of consultant or lesser rank, use private hospital facilities, this will often be as a contractor for the services the hospital provides or as an independent consultant. Liability would thus depend upon whether damage was caused by the consultant's negligence, a procedure or product for which the hospital would be responsible, either directly or vicariously through other employees.

These and related matters are discussed infra,[116] although the standard of care, in the absence of an agreed contractual term for a particular outcome, seems to be very similar in contract and delict.[117] It may be noted that hospital practice has also given rise to recognition of

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[115]Discussed infra.

[116]Under the heading of Basis of Liability. See generally Hospitals and Trained Nurses, A. L. Goodhart, 1938 54 L.Q.R. 553 and section 10 (Hospitals), in Charlesworth and Percy on Negligence, op. cit., p. 550 et seq.

[117]Stevenson v. Shafer 1953 S.L.T.(Sh. Ct.) 107; Eyre v. Measday [1986] 1 All E.R. 488; Thake v. Maurice, [1986] Q.B. 644.

some direct delictual duties,[118] inter alia in respect of unsafe systems[119] or insufficiently experienced staff.[120] A judicial attitude indicating greater flexibility than one might have expected may be apparent in a recent case in this area which was originally and erroneously pled in contract. It was allowed to proceed to proof after major amendment of, and answers to, the closed record being made to convert the fundamental basis of the case to delict.[121]

These matters, however, are more properly the province of the modern law, and it is to this which the thesis now turns: the bases of liability.

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[118]Recent suggestions for the extension of this ground of liability may be found in Wilsher v. Essex Area Health Authority [1986] 3 All E.R. 801, C.A., per Glidewell L.J. at p. 831g - h, and per Sir Nicolas Browne-Wilkinson V.-C., at p. 833j - 834c.

[119]Collins v. Hertfordshire County Council and Another [1947] 1 All E.R. 633.

[120]Jones v. Manchester Corporation [1952] 2 All E. R. 125.

[121]Jones v. Lanarkshire Health Board 1990 S.L.T. 19.

The Bases of Liability

This thesis has already considered briefly the historical development of the law of medical negligence in Scotland and England. Although a significant proportion of this remains relevant today, it requires to be brought up to date, including some consideration of recent changes to the health service and to liability for negligence. Accordingly, this part of the chapter seeks to outline the legal bases of liability of a doctor sued in Scotland for damages for medical negligence. It focusses mainly upon the Scottish, National Health Service hospital doctor or general practitioner acting within the scope of his employment; private practice is also considered where appropriate.

The basis of liability for medical negligence may be analysed in essentially two ways. It may mean firstly whether a claim is brought in contract or delict. This is determined by whether the patient in question consults the doctor privately or under the National Health Service,[1] an organisation established in 1947-48 "..to secure improvement in the physical and mental health of the people of Scotland and the prevention, diagnosis and treatment of

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[1]No guarantee of treatment by any individual doctor is given under the National Health Service. Although the doctor could agree to alter the usual standard of care without payment, the essential randomness of allocation of doctor does imply that whatever standard of care be imposed be in general, or objective, terms.

illness..".[2] When consultation is sought privately, the parties will be free to agree such terms as they wish. These may include a term guaranteeing a particular result or altering the standard of, or indeed the existence of the duty of, care. However, such a term is unlikely to preclude the co-existence of a duty in delict or tort.[3] Normally, however, the existence and content of a contractual duty will be similar to that which applies in delict or tort,[4] and the courts have indicated that they will be reluctant to imply terms departing from this into such a contract, in the absence of express stipulation by the parties.[5] Secondly, the basis of liability in this context may refer to whether the claim is brought against a general practitioner, against a health authority for

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[2]National Health Service (Scotland) Act 1947, c. 27, s. 1(1).

[3]Edgar v. Lamont 1914 S.C. 277; Gladwell v. Steggal (1839) 5 Bing. (N.C.) 733 (clergyman also acting as medical man); Edwards v. Mallan [1908] K.B. 1002 (dental negligence). In other areas in the law of negligence, contractual and tortious duties are owed simultaneously; Esso Petroleum Co. Ltd. v. Mardon [1976] 2 All E.R. 5 (Court of Appeal), supported by the House of Lords in Pirelli General Cable Works v. Oscar Faber and Partners [1983] 1 All E.R. 65; cf. recent developments reducing the incidence of duties of care and recovery of damages for defective buildings: Murphy v. Brentwood District Council [1990] 3 W.L.R. 414 (House of Lords); also the case of Tai Hing Cotton Mill Ltd. v. Liu Chong Hing Bank Ltd. and Others [1986] 1 A.C. 80 (P.C.).

[4]Thake and Another v. Maurice [1986] 1 All E.R. 479; also Eyre v. Measday [1986] 1 All E.R. 488.

[5]Thake and Another v. Maurice, supra; Eyre v. Measday, supra.

direct liability,[6] for vicarious liability in respect of employed medical personnel, or contractually in respect of private treatment. For a pursuer, it will be attractive to sue an institution if the alternative were an individual, because of potential difficulties in identifying the doctor or for financial reasons after the introduction of Crown indemnity. These "structural" possibilities will be considered after the substantive matters of actions raised in contract and delict. In doing so, it is the purpose of this section to expound the legal bases of the present action for damages for medical negligence.

Contractual Aspects

Prior to the establishment of the National Health Service in 1947-48, the law relating to the liability of a medical practitioner in contract had developed substantially because of cases brought in respect of private treatment.[7] The simplest example is where a patient consults his

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[6]Such as a failure to provide a proper system of healthcare, or perhaps in the negligent appointment of an unqualified doctor. Direct liability was canvassed by Mustill L.J. at p. 811b - 812b, in whose opinion Glidewell L.J. generally concurred, in Wilsher v. Essex Area Health Authority [1986] 3 All E.R. 801 (C.A.). Although the pleadings were not framed in terms of direct liability (cf. Pain J.'s opinion at first instance, considered by Mustill L.J., ibid.), it may not be too great an exaggeration to consider this as a suggestion for future cases.

[7]E.g. Dickson v. Hygienic Institute 1910 S.C. 352; Morris v. Winsbury-White [1937] 4 All E.R. 494. However, even in 1914 claims were being allowed in delict in respect of a private consultation: Edgar v. Lamont 1914 S.C. 277.

general practitioner privately in the latter's practice, or the patient's home. As has been commented, the ambit of the medical "retainer" is both narrow and readily ascertainable, and is restricted to the patient's health, usually in connection with a specific matter.[8] If the law of contract forms the bedrock of the liability of private medical practitioners, it is by no means irrelevant, however, to health service general practitioners. The Secretary of State for Scotland was charged with responsibility under the National Health Service (Scotland) Act 1978[9] to establish the Scottish Medical Practices Committee, a body responsible for ensuring adequate numbers of medical practitioners undertaking to provide general medical services within the area of each Health Board,[10] and administering the list of these approved practitioners. The responsibility actually to provide such services is placed by section 19 of that Act upon the local health board:

> "[I]t shall be the duty of every Health Board, in accordance with regulations, to make as respects their area arrangements with medical practitioners for the provision by them of personal medical services for all persons in the

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[8]Professional Negligence, A.M. Dugdale and K.M. Stanton, Butterworths, second edition, 1989, at p. 38.

[9]C. 29, s. 3

[10]S. 3(1). In England, the Medical Practices Committee fulfils a similar function.

area who wish to take advantage of the arrangements..."[11]

In England, a similar approach has been followed, save that the statutory body concerned to provide the relevant services is the Family Practitioner Committee.[12] It may be seen from this that general practitioners are not actually employed by the Health Board (or Family Practitioner Committee), and are therefore independent contractors who agree to provide the required services. These doctors practice in partnerships, to which the common law of partnership, and the Partnership Act 1890, apply. Such practices may be "traditional" in outward appearance, or alternatively a statutorily-empowered "Health Centre", which may provide a multi-disciplinary practice with inter alia general medical, dental, pharmaceutical, specialist out-patient, health education and other services and facilities.[13] In March 1987, 184 such centres were in operation in Scotland.[14] Although perhaps resembling miniature hospitals, they nevertheless remain partnerships, even if larger and more complex than the norm. It is

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[11]National Health Service (Scotland) Act 1978, c. 29, s. 19(1).

[12]In 1984, these were transferred to regulation under the Health and Social Security Act 1984.

[13]National Health Service (Scotland) Act 1978, s. 15. The Secretary of State was empowered by this provision to delegate to, provide staff for, and regulate the internal charges for services (for example dental services) in relation to health centres.

[14]Health in Scotland 1987, SHHD, HMSO 1988 at p. 37.

generally accepted that there is no contract between N.H.S. doctor and patient, whether a hospital consultant or general practitioner.[15]

Terms of Service, the provisions laid down relating to patient-care and kept up to date by the relevant authority, provide a basis for the contract between doctors whose names are recorded on the Medical List and that body for the treatment of patients in the practice locality.[16] General medical practices are therefore independent contractors to the health service; this is unaffected by fundholding practices, which enjoy greater financial autonomy but are not distanced from the health service.

Partners in a general medical practice usually employ assistant doctors to assist them in carrying out these obligations, as well as nursing, para-medical and other staff. Thus, the patient's contact with a health service

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[15]E.g. Michael Jones, Medical Negligence, Sweet and Maxwell, 1991, at p. 14-15. Cf. Walker on Delict, op. cit., second edition, 1981, at p. 1057 and Jackson and Powell, Professional Negligence, third edition, Sweet and Maxwell, 1992, at p. 448 footnote 7, in which it is tentatively suggested that the inclusion of the patient's name on the G.P.'s register, thereby increasing the doctor's fee income, might constitute consideration for their contractual relationship. The present writer respectfully disagrees with both these views so far as Scots law is concerned, although it seems likely that this remuneration could constitute consideration in English law.

[16]It is noteworthy that s. 19(3) of the National Health Service (Scotland) Act 1978 provides that the remuneration of general practitioners shall not be "wholly or mainly" by way of a fixed salary unrelated to the number of patients in the care of that practitioner. In other words, the number of patients registered on the doctor's list of those for whom he is responsible will affect his income.

general practitioner or other health professional is affected by this matrix of contractual obligations.

It has been argued that the acceptance by such a doctor of a patient on to his practice list, i.e. those for whom he is professionally responsible,[17] constitutes a contract between the doctor and the patient, with the additional fee which the doctor receives forming any required consideration.[18] It may be observed that Scots law, not requiring consideration, might perhaps more readily accept such an analysis. However, in arguing against the existence of a contractual relationship between health service doctor and patient, Blackie states that "[T]his is because the doctor is performing an obligation in terms of the National Health Service Acts...".[19] Although this view does not explicitly refer to general practitioners as opposed to hospital doctors, it is thought sufficient to explain the legal basis of the relationship. Thus, the Scottish patient is receiving a benefit analogous to a jus quaesitum tertio, although the present writer is

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[17]A general medical practitioner under the health service treats those patients on his practice list, visitors to his area, accident/emergency cases and those whom no other doctor will accept on to his list, being allocated by the Health Board.

[18]See Professional Negligence, R.M. Jackson and J.L. Powell, Sweet and Maxwell, third edition, 1992, at p. 448 et seq.

[19]See the chapter covering the medical law of Scotland, by J.W.G.Blackie, in Medical Responsibility in Western Europe, ed. E. Deutsch and H.-L. Schreiber (Research Study of the European Science Foundation, Springer-Verlag, Berlin, 1985) at p. 572.

unaware of any health service case which has been argued on this basis.

More complex is the situation in which the patient consults privately a specialist in hospital practice or requires an operation in hospital. At this point, the hospital's management body and other staff are involved: in addition to the contract between patient and doctor, there is likely to be a contract between hospital and patient. Purely delictual duties will co-exist as well.[20] The courts will be slow to imply terms into contracts for private medical care which guarantee results.[21]

The effect of the relationship between doctor and private hospital is less clear, as the doctor may well be an independent contractor, rather than an employee of the separate persona of the body managing or operating the hospital. Consultant and other doctors in the health service who also practice privately, in hospitals or consulting rooms, are likely to be subject to a contract for services with that hospital rather than a contract of employment, thus raising difficulties for recovery of damages by the patient vicariously against the hospital. However, it is possible that liability might arise in

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[20]Sir John Donaldson, M.R., in Hotson v. East Berkshire Area Health Authority [1987] 2 All E.R. 210 at p. 216, said that he was unable to state a justification for any difference in the content of duties of care owed by a doctor in contract and in tort.

[21]Eyre v. Measday, supra, and Thake v. Maurice, supra.

respect of either negligently allowing an unsuitable doctor to practice in the hospital, or the negligent carrying out of any function which that hospital contracted to do. Such liability could arise under contract, if one existed, but would be more likely to arise by breach of a direct duty under the law of delict. Although the contents of duties of care are analysed elsewhere,[22] they appear to be similar whether arising in contract or in delict.[23]

Delict

This appears to be by far the most common basis of liability for claims in medical negligence, and is to be derived ultimately from the principles regarding liability for personal injury in Donoghue v. Stevenson,[24] which has been unscathed by the recent developments in negligence.[25]

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[22]Infra, in the chapter on the standard of care.

[23]See Edwards v. Mallan [1908] 1 K.B. 1002, in which the patient averred want of reasonable care by a privately engaged dentist, which was dealt with by the court as an action based upon tort and not contract. Also Naylor v. Preston Area Health Authority [1987] 1 W.L.R. 958 and Eyre v. Measday [1986] 1 all E.R. 479.

[24][1932] A.C. 562. See, The Analysis of Negligence, in Introductory Essays on Scots Law, W. A. Wilson, second edition, W. Green and Son, 1984, at p. 138 et seq.

[25]E.g. Tai Hing Cotton Mill Ltd. v. Liu Chong Hing Bank Ltd. and Others [1986] 1 A.C. 80 (P.C.), Murphy v. Brentwood District Council [1990] 3 W.L.R. 414, Department of the Environment v. Thomas Bates and Son Ltd. [1990] 3 W.L.R. 457, Parkhead Housing Association v. Phoenix Preservation Ltd. 1990 S.L.T. 812.

As Blackie comments, liability may arise either vicariously, or directly from the acts or omissions of the person concerned.[26] This may in appropriate circumstances include joint contributions to delicts;[27] it seems that, at least in England, cases involving the liability of hospitals form the most common and increasing category.[28] Issues of liability to third parties usually arise outwith the health service context, as in the case allowing a proof before answer in respect of the actings of a senior medical officer to the Department of Transport in relation to the employment of a driver of an omnibus.[29]

The usual basis for liability is in turn predicated upon the basis of the most common contact between doctor and patient - consultation under the National Health Service, originally constituted by the National Health Service Act 1947[30] and in Scotland governed primarily by the National Health Service (Scotland) Act 1978.[31] [32]

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[26]See the chapter covering the medical law of Scotland, by J.W.G.Blackie, in Medical Responsibility in Western Europe, ed. E. Deutsch and H.-L. Schreiber (Research Study of the European Science Foundation, Springer-Verlag, Berlin, 1985) at p. 595.

[27]See the chapter covering the medical law of Scotland, by J.W.G.Blackie, in Medical Responsibility in Western Europe, ed. E. Deutsch and H.-L. Schreiber (Research Study of the European Science Foundation, Springer-Verlag, Berlin, 1985) at p. 595.

[28]Litigation for Medical Accidents, C. Dyer, 1988 B.M.J. 1058.

[29]Johnstone v. Traffic Commissioner 1990 S.L.T. 409 (Outer House).

[30]c. 27

[31]c. 29

As discussed above, it is submitted that there is no contract between doctor and patient in contact under the National Health Service[33] and that the contents of contractual and delictual duties of care are similar: the relatively early case of Edgar v. Lamont,[34] although occurring before the establishment of the health service, provides some Scottish support for the proposition that a doctor's delictual duty is co-extensive with any in contract.[35]

Although recent developments in duties of care have concentrated upon the provision of information,[36] many different aspects of the duty have already been identified. Cameron discusses duties concerning consent, disclosure of

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[32]"Changes in activity in the [N.H.S.] hospital sector between 1986 and 1987 were generally in line with long-term trends; more inpatients were treated in fewer beds and the number of new outpatients also continued to increase." Health in Scotland 1987, S.H.H.D., H.M.S.O., 1988, at p. 23.

[33]It receives explicit recognition in the chapter covering the law of Scotland, by J.W.G.Blackie, in Medical Responsibility in Western Europe, ed. E. Deutsch and H.-L. Schreiber (Research Study of the European Science Foundation, Springer-Verlag, Berlin, 1985) at pp. 571-572.

[34]1914 S.C. 277

[35]Gladwell v. Steggal (1839) 5 Bing. (N.C.) 733. If this was so before 1947, it is more likely to be the case after that date. Cf. D.M. Walker, Delict, W. Green & Son, 1981 at p. 1057, where the author suggests that this relationship is based upon contract. Cameron considers firmly that the standard basis for such claims is in delict: Medical Negligence: An Introduction, J.A.Cameron Q.C., Law Society of Scotland, 1983 at p.9. See also Stevenson v. Shafer 1953 S.L.T. (Sh. Ct.) 107.

[36]E.g. Moyes v. Lothian Health Board 1990 S.L.T. 444, Goorkani v. Tayside Health Board 1991 S.L.T. 94.

mishap, communication, keeping up to date with developments and acting within the area of the doctor's competence.[37] Undertaking work beyond the doctor's competence, and failure to take precautions, prevent illness or attend or examine a patient have also been identified,[38] and the duty extends to liability for illegible handwriting on a prescription form.[39]

Hospitals and Health Authorities

> "Vicarious liability in the law of tort may be defined as a liability imposed by the law upon some person as a result of (1) a tortious act or omission by another, (2) some relationship between the actual tortfeasor and the defendant whom it is sought to make liable, and (3) some connection between the tortious act or omission and that relationship. In the modern law there are three and only three relationships which satisfy the second requirement of vicarious liability, namely that of master and servant,

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[37]Medical Negligence: An Introduction, J.A. Cameron, Q.C., Law Society of Scotland, 1983, ch.4.

[38]For discussion, see Professional Negligence, R.M. Jackson and J.L. Powell, third edition, Sweet and Maxwell, 1992, ch. 6.

[39]Prendergast v. Sam and Dee Ltd and Others, Times Law Reports, 14 March 1989, in which a doctor was held 25% liable for injury occurring following the incorrect interpretation of illegible handwriting on the prescription. The pharmacist was held 75% liable for misreading it, as he should have been on inquiry that the drugs thus prescribed were an unlikely combination. In Dwyer v. Roderick and Others, Times Law Reports, 12 November 1983, a negligent major over-prescription of a drug resulting in serious necrosis gave rise to a liability ultimately of 45% to the doctor mis-prescribing and 45% to the pharmacist who had not noticed the apparently obvious error. See Writing a Wrong, Kenneth Mullan, 1988 297 B.M.J. 470.

> that of principal and agent, and that of employer and independent contractor."[40]

Consideration of the liability of hospitals and health boards or authorities requires a distinction to be made, in effect between the position before the establishment of the National Health Service in 1947-48 and that obtaining subsequently. Before this, it was thought that hospital authorities were not vicariously responsible for the negligence of their professional staff.[41] Thus, it could be said that during the period in question

> "..the bulk of Scottish decisions supports the view that hospitals and nursing homes are not liable to patients for negligence on the part of their professional staffs acting in their professional capacity. Scots law, of course, has its roots firmly embedded in civil law with its distinction between locatio operarum and locatio operis."[42]

As this suggests, liability on the part of the hospital body was accepted only in relation to administrative or managerial delicts committed by such staff[43] and excluded vicarious liability for the professional activities of the professional staff. The rationale for this was that the hospital only held itself out as providing the institution

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[40]Vicarious Liability in the Law of Torts, P.S Atiyah, Butterworths, 1967, at p. 3.

[41]Discussed in Professional Negligence, R.M. Jackson and J.L. Powell, Sweet and Maxwell, third edition, 1992, at p. 490 et seq.

[42]Quoted from Hospitals' Liability for Negligence, Anon., 1949 S.L.T. (News) 1 at p. 1. The emphasis is added.

[43]See Hillyer v. Governors of St. Bartholomew's Hospital, [1909] 2 K.B. 820.

at which patients could consult the doctor,[44] and was a variant on the theme of the "control" test used generally in the law of employment to determine the legal status of a given person. The applicable legal principles were thus partly governed by the structure of the hospital and the profession at that time. Before the establishment of the health service, on occasion some doctors gave their services either free of, or for a nominal, charge in respect of sessions at voluntary hospitals for the poor, a factor influencing the courts' reluctance to hold the institution liable.[45] The analysis in Hillyer v. Governors of St. Bartholomew's Hospital,[46] that hospital managers were not legally responsible for the doctors working in the hospital, was followed in subsequent Scottish cases, for example, Scottish Insurance Commissioners v. Royal Infirmary.[47] The function of the hospital management was

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[44]Paraphrasing the view of Lord Dunedin in Scottish Insurance Commissioners v. Edinburgh Royal Infirmary 1913 S.C. 751. This is quoted in Hospitals' Liability for Negligence, Anon., 1949 S.L.T. (News) 1 at p. 1.

[45]"It is very difficult to avoid the conclusion that most of the earlier decisions regarding voluntary hospitals (or hospitals that were assumed to be voluntary) were deeply influenced by the desire to protect charitable funds from claims for damages, though it is not easy to see why, in this view, a charitable hospital should be liable for the negligence of its domestic servants but not of its medical staff." Lord President Cooper, in MacDonald v. Glasgow Western Hospitals 1954 S.C. 453, at pp. 476 - 477.

[46][1909] 2 KB 820

[47]1913 SC 751. This case considered whether the doctors were employed by the hospital for the purposes of a statute, the National Insurance Act 1911, c. 55.

thus regarded essentially as an administrative one,[48] and liability could therefore arise only in respect of a limited range of circumstances. These included direct liability for the negligent performance of the restricted functions undertaken by that management, vicarious liability for servants acting under its direction, and other forms of direct liability such as improper delegation. As far as liability for the exercise of professional skills was concerned, although vicarious liability for employees as such was recognised by Scots law at the time, the difficulties concerned whether the doctor was merely a (regular) independent contractor, was or was not employed and whether a professional person who was not directed as to the exercise of his skill but who was nevertheless employed could be part of the doctrine of vicarious liability. It was at the time well established that the only liability applicable to these doctors was direct liability to the patient only in respect of their own delicts or torts. They were not thought to be employees.

In Scotland, the scope and basis of liability were greatly expanded following upon the establishment of the health service. This expansion was largely effected by the

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[48]An alternative analysis might be made in terms of the law of agency. This might raise the possibility of the agent's liability for the doctor principal; so far as the present writer is aware, no attempt to analyse matters in this way has been presented.

cases of MacDonald v. Board of Management for Glasgow Western Hospitals,[49] extending liability to house officers, and Fox v. Glasgow South Western Hospitals[50] in respect of nurses. The previous leading decision, that of Reidford v. Magistrates of Aberdeen,[51] was effectively disapproved.[52]

The question which had caused difficulties, that of vicarious liability for the exercise of professional skills by employees, was thus resolved. It may be observed that the timing of these cases reflected the increase of indisputable instances of medical employment in the health service in all categories of medical staff.[53] A further acknowledged factor in this change was the new statutory basis of the hospitals.[54]

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[49]1954 S.C. 453

[50]1955 S.L.T. 337

[51]1933 S.C. 276

[52]Opinion of the Lord President (Cooper) in MacDonald v. Glasgow Western Hospitals 1954 S.C. 453 at pp. 473-474. At p. 474 he states that "I part with Reidford with the observation that I am unable to extract from the opinions any single and clear ratio decidendi, except that the averments of the pursuer in that case were irrelevant."

[53]Previously, many doctors of consultant grade would not truly have been employed by the hospital authority but would have been visiting specialists. Liability based upon agency (e.g. Roe v. Minister of Health [1954] 2 Q.B. 66, opinion of Lord Denning) has also been canvassed, and it is thought that the doctrine of pro hac vice employment would provide another route to the same destination.

[54]MacDonald v. Glasgow and Western Hospitals Board 1954 S.C. 453 per Lord President Cooper at p. 473.

However, without resorting to artificial concepts, the (English) Court of Appeal had held in 1942 that a radiographer was in fact employed by the hospital body, thereby opening the way to recognition of vicarious liability and reducing the narrower, Hillyer-type approach which had previously obtained. It is noteworthy that Lord Denning was instrumental in expanding the scope of vicarious liability, considering that hospitals chose the specialists from whom the patient would receive treatment, the latter having little control over this process, and including also the doctor's source of remuneration.[55] This reflected the increasing technical complication of medicine, in which the hospital could no longer be seen as merely the place where doctor and patient met.[56] It may be observed that these decisions are based upon the liability of an employer and therefore are still likely to be inapplicable to any person - most likely to be a doctor of consultant rank - who may visit a hospital for one clinic or operating session every week or fortnight, but who cannot be regarded as being employed by that institution. If he were employed elsewhere within the area of a given health board, vicarious liability would cover this possibility. Otherwise, it is likely that the only other

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[55]Per Lord Denning, in Cassidy v. Ministry of Health [1951] All E.R. 574, at p. 586d - 586h.

[56]Janet Bettle, Suing Hospitals Direct: Whose Tort was it Anyhow? 1987 137 N.L.J. at p. 573.

method of rendering a hospital or health authority with perpetual succession liable would be by direct liability.[57] It is interesting to note that once a general practitioner has referred a case to his hospital colleague, the latter takes over entirely the de facto care of that patient, until he or she is released from hospital. This has the effect of removing the general practitioner largely or entirely from the risk of an action for damages during this period. This state of affairs may be contrasted with that obtaining where a client engages a solicitor and counsel in litigation. From the solicitor's point of view, the possibility of a claim for negligence where counsel's advice has been relied upon appears to be increasing.[58]

Direct Liability and Recent Developments

Although since the inception of the National Health Service there has been greatly increased reliance upon vicarious liability, there is a little evidence that direct liability may be ripe for increased emphasis. It has been

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[57]Considered infra. Although the details are as yet unclear, it may be that the optional new self-governing trust status for health service hospitals may make this a more real problem than of late. Even so, if a health authority continues to be responsible for the provision of healthcare and damages under crown indemnity, little change may in fact be evident. The health service or authority is not vicariously liable for general practices at present anyway, so self-governing status for these is unlikely to bring about any change in patterns of liability.

[58]Are Solicitors Liable for Counsel's Negligence? A.R.W. Young, 1990 S.L.T. 177.

persuasively argued by Bettle that there exists authority for holding a hospital, or a health authority (in respect of which the same arguments would seem to apply) directly liable to the patient.[59] Two strands of this argument may be identified, one much less extensive than the other. The first is based upon relatively recent dicta in Wilsher v. Essex Area Health Authority:[60]

> "..a health authority which so conducts its hospital that it fails to provide doctors of sufficient skill and experience to give the treatment offered at the hospital may be directly liable in negligence to the patient. Although we were told in argument that no case has ever been decided on this ground and that it is not the practice to formulate claims in this way, I can see no reason why, in principle, the health authority should not be so liable if its organisation is at fault."[61]

By virtue of Glidewell L.J.'s (undernoted) concurrence, this assumes the status of a majority view, albeit obiter:

> "..I agree with Sir Nicolas Browne-Wilkinson V.-C. that there seems to be no reason in principle why, in a suitable case different on its facts from this, a hospital management committee should not be held directly liable in negligence for failing to provide sufficient qualified and competent medical staff."[62]

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[59]Suing Hospitals Direct: Whose Tort is it Anyhow? 1987 137 N.L.J. 573.

[60]In the Court of Appeal: [1986] 3 All E.R. 801. The House of Lords dealt only with the causation issue.

[61]Per Sir Nicolas Browne-Wilkinson V.-C., Wilsher, ibid., at p. 833h, j: quoted by Bettle, ibid., at p. 574.

[62]Per Glidewell L.J., Wilsher, ibid., at p. 831g-h.

Indeed, there is some prior consideration[63] by the Court of Appeal of direct liability. This was in the case of Jones v. Manchester Corporation,[64] in which an inexperienced doctor, five months' qualified, administered pentothal general anaesthetic to a patient already partly anaesthetised by nitrous oxide gas. The patient died immediately. A majority (Singleton L.J. and, unsurprisingly,[65] Denning L.J. as he then was) held[66] that not only had the doctor been negligent but suggested that direct liability was also involved.[67] The effect of this

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[63]The pleadings in the case apparently did not contain anything to support a case of direct liability against the employer. Thus the judicial dicta in support of this possibility must be viewed as obiter.

[64][1952] Q.B. 852

[65]In view of his opinion in Cassidy v. Ministry of Health [1951] 2 K.B. 343, albeit involving res ipsa loquitur.

[66]The full indemnity ordered at first instance, by the Corporation in favour of the doctor, was varied by majority on appeal to the extent that the doctor was to be 20% liable and the responsible authority 80% liable. This was an apportionment under the Law Reform (Married Women and Tortfeasors) Act 1935, Denning L.J. opining that no issue of the indemnity of the employer by employee should arise. However, Hodson L.J. (as he then was) dissented, holding that a term required to be implied into the contract of employment between doctor and Corporation, to the effect of exercise of the appropriate degree of skill and care by the doctor. Breach of this in turn entailed full indemnity from the doctor qua servant; the only liability arising on the part of the employer was vicarious, as opposed to direct, liability.

[67]The opinion of Singleton L.J. does not make it clear what the basis for his finding the Corporation directly liable was. However, it seems that the lack of instruction of Dr Wilkes as to anaesthesia in such a difficult case, and the negligence of her more experienced colleague, Dr Sejrup, although the latter was not a co-defendant in the case, influenced the decision. Support for this is gleaned from the following passages: "Dr

was to render the doctor liable for one fifth of the damages, but the employer four fifths liable. In fact, as joint tortfeasor under the provisions of section 6 of the Law Reform (Married Women and Tortfeasors) Act 1935, the indemnity sought by the Corporation was precluded. The substantial difference between the majority opinions and the dissent by Hodson L.J. (as he then was) never fails to surprise and intrigue the present writer.[68]

As Bettle argues, the form of direct liability somewhat enigmatically referred to by their Lordships seems to be limited: if based upon the existing law, then

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Sejrup was the senior, and he was a servant of the hospital board. So far as we know, neither of these young doctors had been given any instruction as to the danger of using pentothal when a patient was still partly unconscious from the use of nitrous oxide, or of the great need for careful watching in such a case" (at p. 864); "[T]he employer cannot have a right of indemnity if he himself has contributed to the damage, or if he bears some of the responsibility therefor; and the same reasoning applies if some other and senior employee's negligence has contributed to the damage." (at p. 865). Denning L.J. states in forthright terms that "..at common law even if the negligence is only that of one doctor alone, nevertheless the hospital board is a joint tortfeasor with him and cannot at common law claim contribution or indemnity from him." (at p. 869).

[68]As a matter of legal analysis, the present writer is inclined to sympathise with the view of Hodson L.J.; no doubt there was a term in the contract between doctor and employer that reasonable care and skill should be employed in the treatment of patients. Breach of this would give rise to a right of damages for any loss accruing; presumably such loss would include damages for negligence and thereby imply the general indemnity of an employer vicariously liable for an employee's negligence. The application of the provisions of the 1935 Act would seem to require holding ab initio that the employer was a joint tortfeasor. So to hold suggests that all anaesthetic mishaps occurring via junior doctors at that time would mean liability and breach of a direct duty of care on the part of all employing health authorities.

clearly no radical innovation could be envisaged. Bettle comments that it would presumably extend as far as the efficient running and staffing of the hospital.[69] However, the more extensive - and interesting - possibility canvassed is that of the non-delegable duty of care. Other than the more recent Canadian case of Yepremian et al. v. Scarborough General Hospital,[70] the English authority advanced in support of this theory is largely prior to the establishment of the health service and the changes in the law which took place following it.[71] Modelled, as Bettle says, upon the concept in employment law devised to avoid the strictures of the doctrine of common employment, the non-delegable duty under consideration would mean that the authority would be liable even for the negligence of doctors in its employ - because of the non-delegable duty directly owed. Bettle identifies three possible analyses of a hospital's or health authority's liability:[72]

(1) A non-delegable duty is owed by the hospital to the patient. The content of this duty is to take reasonable care in the treatment and general

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[69]Bettle, op. cit., at p. 574.

[70]1985 110 D.L.R. (3d) 513.

[71]A more recent Australian case, Kondis v. State Transport Authority [1984] 58 A.L.J.R. 531 is considered by Bettle, op. cit., at p. 574.

[72]Bettle, ibid., at p. 576.

management of that patient. Therefore any treatment negligence, even perpetrated by professional medical staff would constitute the hospital's tort, because the obligation vested only in the authority.

(2) The second possibility is the less extreme version of this, to the effect that the hospital or authority concerned has a (direct) duty to provide and to organise the appropriate medical and other staff. Clearly, such a duty would only have meaning when applied to the hospital or authority and could not thus be delegated. It is observed in passing that the dicta referred to by Bettle[73] support this possibility rather than (1) above, particularly that of the Vice-Chancellor in Wilsher, which is worth setting out in full:

> "[C]laims against a health authority that it has itself been directly negligent, as opposed to vicariously liable for the negligence of its doctors, will, of course, raise awkward problems. To what extent should the authority be held liable if (e.g. in the use of junior housemen) it is only adopting a practice hallowed by tradition? Should the authority be liable if it demonstrates that, due to the financial stringency under which it operates, it cannot afford to fill the posts with those possessing the necessary experience? But, in my judgment, the law should not be distorted by making findings of personal fault against doctors who are, in truth, not at fault in order to avoid such questions.

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[73] I.e. those in the case of Wilsher, ibid.

> To do so would be to cloud the real issues which arise".[74]

(3) The third possibility is confined to that which is presently well-established: that the hospital's or authority's liability to its patients is based upon an employer's vicarious liability, without any necessity to rely upon any non-delegable duty in respect of the actual provision of treatment. Of course such an approach would allow direct liability for breach of other duties, such as one, for example, to take reasonable care in making appointments of professional staff.

Whilst anticipating difficulties with each of the possibilities identified, Bettle concludes that the direct, non-delegable duty is at least a stateable possibility and one to which plaintiffs' advisers should turn in addition to more established heads of liability.

The non-delegable duty of care thus contended for has been subjected to criticism by Montgomery.[75] A point advanced is that the test for breach of the non-delegable duty in respect of patient care by a doctor would involve

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[74]Per Vice-Chancellor Sir Nicolas Browne-Wilkinson in Wilsher, ibid., at p. 833. Quoted in full by Bettle, ibid., at p. 576.

[75]Suing Hospitals Direct: What Tort? Jonathan Montgomery, 1987 137 N.L.J. 703.

applying the Bolam test[76] and imputing any breach thereof to the authority or hospital. To do so would be artificial. Particularly since vicarious liability has been well-established since the 1950s, this would not lead to any benefit for the plaintiff,[77] or indeed the defendant. Montgomery states[78] that the problem of breach was avoided in the three cases upon which Bettle's argument relies.[79] Whilst this point applies in the case of Cassidy v. Ministry of Health,[80] the other two cases relied upon which he discusses do not seem to bear this out. In Gold, however, "the judge at first instance had found that there had been negligence on the part of the radiographer",[81] and in respect of Wilsher it likewise is acknowledged that there was a finding of fault in respect of the senior registrar, Dr Kawa, even if not the more junior colleague who called him in. So before the issue of the liability, and the test, were finally determined, fault had been considered in detail. It seems, therefore, that to criticise the direct liability hypothesis because it would

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[76]Or one very similar.

[77]Crown indemnity may be seen either as a form of quasi-direct liability (or insurance) or, more properly, as reinforcing conventional employer's vicarious liability.

[78]Ibid. at p. 703.

[79]Cassidy, ibid., Gold, ibid. and Wilsher, ibid.

[80]A case involving res ipsa loquitur.

[81]Montgomery, ibid., at p. 703.

require the application of a Bolam-type test for negligence is unsatisfactory.

Bettle's thesis is also criticised on the grounds that "..[S]he appears to suggest that there is strict liability for any damage caused after there is a failure to provide reasonable care."[82] It is respectfully suggested that this was intended to mean that "..there is strict liability on the part of the hospital for any damage caused after there is a failure to provide reasonable care by the doctor..". If this is correct, it is submitted that this does not refer to strict liability in the usual sense of the term, and furthermore that the de facto breach of the hospital's duty by the doctor is not strict liability but breach of a re-drawn duty of care. However, the points regarding allocation of resources and questions of discretion are, it is submitted, well made,[83] as is that concerning patient-selected doctors in a private context, which would exclude the direct liability under consideration. Whilst arguing that Bettle-type liability would add little to the present system, Montgomery nevertheless argues in favour of the greater accountability of the new health service managers.[84] He concludes that,

> "[T]o treat health authorities as if their control over their servants was absolute is unrealistic. Doctors in particular retain a high

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[82]Montgomery, ibid., at p. 703.

[83]Montgomery, ibid., at p. 704.

[84]Montgomery, ibid., at pp. 704-705.

> degree of professional autonomy within the National Health Service. To hold the organisation liable for professional errors would be to introduce a legal fiction which would do nothing to clarify the allocation of responsibility in health care. What is needed is an analysis which will hold individuals accountable for their personal decisions, but which also allocates responsibility for ensuring that the professionals operate as a team. This is more likely to be achieved within the framework of a limited direct liability combined with vicarious liability than by imposing a broad non-delegable duty of care."[85]

It is thought unlikely that there will be any increase in the scope of liability of the directly-arising type; it runs parallel to existing duties and heads of liability. Furthermore, recent decisions on the incidence of duties of care by the House of Lords, such as Murphy v. Brentwood District Council[86] and Department of the Environment v. Thomas Bates and Son Ltd.,[87] albeit not involving personal injury but liability for defective buildings and economic loss,[88] strongly suggest a judicial reluctance to countenance any expansion of liability, although in Scotland "the same trend of decisions has yet to manifest

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[85]Montgomery, ibid., at p. 705.

[86][1990] 3 W.L.R. 414. See also Tai Hing Cotton Mill Ltd. v. Liu Chong Hing Bank Ltd. and Others [1986] 1 A.C. 80 (P.C.).

[87][1990] 3 W.L.R. 457

[88]A further example in the field of economic loss, although involving consideration of Hedley Byrne-type factors such as reliance upon professional advice, is Al Saudi Banque and Others v. Clark Pixley [1990] 1 Ch. 313, a decision of Millet J. It was held that the auditor of the accounts of a company did not owe a duty of care to prospective commercial creditors (banks) of a company which subsequently was compulsorily wound up.

itself".[89] It has been argued, however, that there is a general trend in the United Kingdom's labour market away from the traditional analysis of part-time and full-time employees towards independent contractors. Although vicarious liability would not prima facie be applicable in such cases, it has been argued that for the purposes of protecting plaintiffs, it should be.[90] If such a policy-based argument may be presented in relation to the general sphere of employment law, it is strongly arguable, it is submitted, that the de facto responsibility of consultant doctors should also be so reflected.

It is clear that direct liability, despite some judicial references to it, has hitherto played a minimal role in the regulation of liability for negligence. However, following the introduction of N.H.S. indemnity in

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[89]The Future of Liability for Defective Buildings, H. L. MacQueen, 1990 S.L.T (News) 337 at p. 337. MacQueen also discusses the Scottish cases of Parkhead Housing Association v. Phoenix Preservation Ltd. 1990 S.L.T. 812 and Scott Lithgow v. G.E.C. Electrical Projects Ltd. 1989 G.W.D. 38-1770. In the former, it was held that the facts came within the Junior Books formula, albeit involving physical damage, whereas in the latter it was held that the facts were outwith Junior Books. These are discussed by MacQueen, ibid., at pp. 339-340 (so far as implications on tort/contract relationships are concerned, see inter alia Tai Hing Cotton Mill Ltd. v. Liu Chong Hing Bank Ltd. and Others [1986] 1 A.C. 80 (P.C.)). However, it is thought that (i) the persuasive effect upon Scottish legal advice of the recent English House of Lords cases will be strong, and (ii) in the event that an appropriate Scottish case were appealed to the House of Lords, that the opportunity would be taken by their Lordships to make clear that the laws of the two countries should be the same.

[90]Vicarious Liability and Independent Contractors - A Re-examination, E. McKendrick, 1990 53 M.L.R. 770.

January 1991,[91] all ranks of doctors, including consultants, employed by the N.H.S are indemnified by the Crown for damages awards in respect of negligence, rather than the previous arrangement of sharing liability between the appropriate medical defence organisation and the employing authority.[92] This applies within the scope of the contract of employment, and extends to medical supporting staff as well. Where a hospital has "opted out" of health service control,[93] it becomes a self-governing institution and as such is not covered by the indemnity.[94] It may, however, insure against negligence claims, which Crown bodies, such as hospitals operating within the N.H.S. financial framework, are barred from doing.[95] However, it may be noted that Crown immunity, specifically from interdict, does not apply to Scottish Health Boards constituted under

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[91]Introduced inter alia by Department of Health circulars HC (89) 34 and HC (FP)(89) 22.

[92]Although where large settlements are involved, i.e. exceeding £300,000, or alternatively exceeding 0.15% of a Board's revenue allocation, whichever is the lesser, the Health Department may contribute towards such payment: N.H.S. Circular 1990 (P.C.S.) 3, paras. 1 - 3, and Annex A thereto.

[93]National Health Service and Community Care Act 1990, sections 5 - 12.

[94]Paragraph 12 of the circulars introducing N.H.S. indemnity, cit. sup.

[95]Despite this, paragraphs 31 and 32 of the circulars introducing Crown indemnity (cit. sup.) empower continuation of the risk-pooling by health authorities to meet potentially large claims - a form of self-insurance. For substantial claims, the Department of Health may contribute a proportion of the damages awarded.

the National Health Service Acts.[96] Private practice, and N.H.S. general practice, are excluded from Crown indemnity, although it is conceded by the scheme that a junior N.H.S. hospital doctor who sees a private patient in an N.H.S. hospital, effectively within the scope of his contract of employment, will be included within it.[97]

Funding of successful negligence claims against N.H.S. hospitals and community care units in the transitional period is partly by the medical defence organisations[98] and, in the cases of large settlements (over £300,000) also partly by the Department of Health.[99] Most of the cost of settlements, however, will continue to be borne solely by the appropriate health board, authority or opted-out hospital although there will continue to be relief from the Department of Health for very large (amount unspecified) cases.[100] There is no reason for the liability, or existing indemnity insurance arrangements, of general practices to

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[96]British Medical Association v. Greater Glasgow Health Board 1989 S.L.T. 493; cf. Lord Advocate v. Strathclyde Regional Council 1990 S.L.T. 158; discussed in, Crown Immunity from Statute, I.S. Dickinson, 1990 S.L.T. 61. Presumably the effect of British Medical Association applies to N.H.S. Trust status hospitals.

[97]Paragraph 5 of the circulars (supra) specifically includes private work performed by junior hospital doctors. Presumably such treatment will in effect be on behalf of the consultant concerned.

[98]N.H.S. Circular (PCS) 32, para. 12.

[99]Ibid.

[100]Annex to Circular (PCS) 32, para. 31.

be changed by opting for fund-holding status. A monitoring system for health service liability costs in negligence is also established,[101] although at the time of writing it is too early for any results or conclusions to be available from this. A doctor sued for negligence where the provisions of Crown indemnity are applicable may, provided the pursuer, other defenders (principally the employer) and the court agree, instruct an independent defence if he wishes to, although the health board would remain liable for the full amount of any damages awarded.[102]

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[101]Circular (PCS) 32, supra, para. 14.

[102]Annex to Circular (PCS) 32, para. 26.

Part II: Standard of Care

Chapter III

The Standard of Care in Medical Negligence Case Law

Introduction

The test for medical negligence is the criterion by which a doctor may be adjudged legally at fault. Assuming the duty of care to be established, the legal concept of "fault" is the first test which a pursuer must satisfy in order to render a doctor liable for negligence. This test is not based upon the reasonable man but instead upon the equivalent reasonable doctor,[1] and, it is submitted, is objective.[2] In the law of medical negligence, the test for breach of this duty of care compares the standard actually exercised by the doctor during the episode in question with an abstract standard, the definition of which is heavily

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[1]Hunter v. Hanley 1955 S.C. 200. More colourfully, "...the standard of care differs - although he might be prepared to give it a try, the reasonable man will not make a very successful attempt at brain surgery." An Introduction to the Law of Delict, W.J.Stewart, W. Green & Son 1989 at p. 60.

[2]See inter alia Hunter v. Hanley supra, Wilsher v. Essex Area Health Authority [1986] 3 All E.R.801 and Jackson and Powell, Professional Negligence, third edition, Sweet and Maxwell, 1992, at p. 38 et seq. A subjective approach to the standard of care in a contractual context was firmly rejected in Wimpey Construction (U.K.) Ltd. v. D. V. Poole, [1984] Lloyd's Repts. 499 (considering Megarry J.'s argument in favour of a subjectively-determined standard in relation to a particular solicitor, at pp. 183-4 in Duchess of Argyll v. Beuselinck [1972] 2 Lloyd's Repts. 172). This adds weight to the view that the contractual and tortious/delictual standards are very similar in this area. See also inter alia Tai Hing Cotton Mill Ltd. v. Liu Chong Hing Bank Ltd. and Others [1986] 1 A.C. 80 (P.C.) and Weir v. Wyper 1992 S.L.T. 579 (O.H.; Lord Coulsfield).

influenced by reliance upon evidence of what other doctors do. This is despite the latent power of the court to hold a common practice negligent.[3] It is submitted that, as a matter of practical reality, a court will be relatively slow to displace strong or especially technical evidence upon the practice of medicine, for the basic reason that however sensible or ethical such evidence may or may not be, United Kingdom judges are not medically trained or qualified. Their assessment of the evidence must therefore be based upon their existing training, with factors such as qualifications and experience of expert witnesses playing a large role.[4] So far as obtaining the patient's consent is concerned, it is clear that the approach of the courts in England (and, it is submitted, Scotland[5]) is to reject

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[3]See K. McK. Norrie, Medical Negligence: Common Practice and the Standard of Care, 1985 J.R. 193.

[4]The role of the expert witness in the American courts has recently been the subject of investigation. The study concluded that for an adversarial system, there are strongly conflicting pressures on such witnesses: An Empirical Examination of the Use of Expert Witnesses in American Courts, A. Champagne, D. Shuman, E. Whitaker, 1991 31 Jurimetrics 375 et seq.

[5]See J.W.G. Blackie, "Scotland", in Medical Responsibility in Western Europe, ed. H.-L. Schreiber and E. Deutsch, Springer-Verlag, Berlin, 1985, at p. 578 et seq.

a "reasonable patient" test[6] such as that favoured in the U.S. in Canterbury v. Spence.[7]

Some categories under which medical negligence may be classified have developed from practice. These have included deviation from common practice, genuine difference of opinion as to type of treatment, and failure to carry out a given procedure properly (this too could be figured as a deviation case). In all of these the formal terms of the test has been the same.

Ultimately, it is thought that short of abandoning the attempt, there is no method of assessing a practitioner for negligence on a given occasion other than by comparing his conduct with a standard. What that standard is, however, may not be as restricted as this basic methodology. The obvious possibilities are, firstly, referring the doctor to some abstract notion of an internal or subjective standard - which is likely to be artificial and problematic. An alternative is to compare the doctor with some external reference standard, be this what his fellow professionals

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[6]See Sidaway v. Governors of the Bethlem Royal Hospital, [1985] AC 871, despite Lord Scarman's powerful dissent in favour of a patient-driven approach where (arguably) non-medical aspects of the doctor's practice are involved, such as information disclosure.

[7](1972) 464 F. (2d.) 772. In Canada, Reibl v. Hughes (1980) 114 D.L.R. (3d.) 1 (S.C.C.) adopted the "prudent patient" test. Consent in medical matters has been the subject of discussion, inter alia in chapters 6 and 7 of A Patient's Right to Know, S.A.M. McLean, Dartmouth, 1989; chapter 9 of Law and Medical Ethics, R.A.A. McCall Smith and J.K. Mason, third edition, Butterworths, 1991, and chapter 4 of Medicine, Patients and the Law, M. Brazier, Penguin, 1987.

actually do, or an absolute standard which may be higher than that exercised in actual practice. Clearly, difficulties arise in attempting to make allowance for genuine differences of opinion.

However, it is submitted that the only standard which ultimately should be applied, whether by a judge or by self-regulation of the profession, is one based involving an external, or absolute standard of practice. Otherwise, the actual practice of a majority or even entirety of a profession might reduce the standard of care, with the assessing body unable to hold any actions in breach of the standard. The extent to which this is assessed by means of actual practice is problematic. At present, much turns upon common practice even though the court probably has the power to hold a common practice negligent. Blackie states that it is standard practice in Scottish pleadings to "..include a specific averment to the effect that no doctor in the position of the defender would have done what was done."[8] It is submitted that such a test of necessity delivers a lower standard of care than is desirable[9], and therefore risks serious over-reliance upon common practice. This approach applies throughout the range of medical activities - in diagnosis, obtaining consent, advice and treatment. It is still a test almost entirely based upon

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[8]J.W.G. Blackie, op. cit., at p. 575.

[9]Even below a notional average standard.

the doctor's view - the "reasonable patient"-type formulation has been rejected.

So far as the more complex situation arising in the case of specialist hospital units is concerned, the test to be applied retains this emphasis upon the individual practitioner performing the medical task. No unit or "team" standard applies; nor does a standard based upon the actual qualifications or experience of the practitioner concerned.[10] The test is thought to be an objective one, based upon the task undertaken.[11]

The actual formulation which we have been considering merely provides the shell of the test. Its actual content obviously depends upon the circumstances of each case - the specialty (or generality) involved, the patient's symptoms, diagnosis, treatment and all other aspects of the medical encounter. In ascertaining the content of the test, the court is only, in effect, told whom to ask rather than what the substantive answer should be. To achieve this, the court requires to act in a way dictated by the fundamentally adversarial system of litigation. It must listen to the testimony of both sides' expert witnesses, take in and understand technical medical evidence, assess and weigh up the different techniques and attitudes put

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[10]Wilsher v. Essex Area Health Authority [1986] 3 All E.R. 801 (C.A.). The House of Lords did not consider issues of the standard of care, but confined themselves to causation.

[11]Wilsher, supra; M. A. Jones, Medical Negligence, Sweet and Maxwell, 1991, at p. 85 et seq.

forward. Only then, having gleaned an idea of what both good and/or usual practice is, will the court be able to adjudicate upon the substantive merits.

It is arguable that as lawyers and judges are intelligent, highly trained and systematic, they therefore are well able to bring their own intellects to bear upon the medical issues. But because the test pertains to form rather than substance then they must necessarily, and will be, heavily influenced by the views of the experts from which they must make a substantive medical judgment with the benefit of hindsight. This is in a fundamentally alien discipline to legal personnel, and is by definition coloured by which side the expert appears upon.[12] It may also be mentioned that the test for medical negligence only applies in cases in which there has occurred harm. Thus, if a doctor is negligent and perhaps by chance no harm results from this, no triable issue of negligence arises.[13] Any deterrence sought by the law must be considered subject to this factor, which, it is submitted, greatly hinders the efficacy of the deterrent or hortatory function of the law.

Consideration of the duty,[14] and standard, of care in

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[12]An Empirical Examination of the Use of Expert Witnesses in American Courts, A. Champagne, D. Shuman, E. Whitaker, op. cit.

[13]Unless perhaps disciplinary procedures before the General Medical Council are invoked.

[14]In this thesis, issues surrounding the duty of care are not discussed in any detail. This is because an N.H.S. doctor's duty of care rarely seems to give rise to dispute. However, there is a wider debate on the relevance of the duty of care analysis in Scots law. Since Donoghue v. Stevenson 1932

cases of medical negligence has in turn given rise to a remarkable variety of issues. Who should be clinically responsible, the test for the standard of care, the effect of common practice,[15] and "team", "post" and junior doctors' competence have all been raised in this context.[16] Furthermore, as the law - and medical practice - have continued to develop, additional questions have been introduced.[17] Examples of these include effective

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S.C.(H.L.) 31, this approach has in effect been by concession. See inter alia, The Analysis of Negligence, in Introductory Essays on Scots Law, W.A. Wilson, second edition, W. Green and Son, 1984, at p. 138.

[15]See The Standard of Care in Medical Negligence, R.B.M. Howie, 1983 J.R. 193; cf. Common Practice and the Standard of Care in Medical Negligence, K. McK. Norrie, 1985 J.R. 145

[16]See Wilsher v. Essex Area Health Authority, [1986] 3 All E.R. 801 (C.A.) and [1988] 1 All E.R. 871 (H.L.).

[17]Hunter v. Hanley 1955 S.C. 200 is conventionally cited as authority in case of deviation from common practice (inasmuch as the needle used was too small). If this is to be the criterion of "deviation", however, then it is submitted that it leaves no place for incompetently-performed "conventional" treatment: there is nothing unconventional about giving a patient an injection. Thus, by definition almost, incompetent treatment may be categorised as a deviation, as long as something no doctor of ordinary skill would do. Whether, where this test is applied, it makes any difference whether the treatment is "conventional" or "deviational" is another question. It may be that the courts will be more ready to hold the so-called deviation cases negligent. Nor does this assist when considering the patient whose doctor does not wish to operate, perhaps on the grounds that operations (like litigation) are risky and should not be lightly undertaken. This might constitute deviation in a specialty commonly undertaking "aggressive" management, or invasive treatments. However, it now seems that this (or an almost identical) test, will be applied to all areas of medical practice, and the use of appropriate experts will counteract this point. This is discussed infra. See also Sidaway v. Board of Governors of Bethlem Royal Hospital and Maudsley Hospital and Others, [1985] A.C. 871.

communication both with the patient[18] and other doctors[19], and issues of duty and confidentiality, for example in relation to patients with acquired immune deficiency syndrome.[20] The writer seeks to argue that the law's approach, both in respect of the fault principle and indeed the mechanics of the present standard of care, is unsatisfactory. It does not inter alia reflect either the reality of the doctor-patient relationship or the responsibilities which should attach to medical personnel, but which are distorted by the existing rules of vicarious liability and Crown indemnity. It will ultimately be argued that the fault principle is inappropriate in cases of medical negligence.[21]

In the wider law of negligence, development of the concepts of the duty of care and foreseeability has

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[18]An early example involving failure to communicate principally with a locum, but also with the patient, is Farquhar v. Murray, 1901 3 F. 859.

[19]Examples are Chapman v. Rix, Times, 19 November 1959, 22 December 1960 and Coles v. Reading and District Hospital Management Committee, (1963) 107 Solicitors' Journal 115, and Fowler v. Greater Glasgow Health Board, 1990 S.L.T. 303. Also in this context generally, see Tehrani v. Argyll and Clyde Health Board (No. 2), 1990 S.L.T. 118 (the consequences of difficulties in communication between doctors, and the individual doctor's redress on termination of contract of employment).

[20]The delictual analysis will be concentrated upon, because it is the most common form of medical encounter. Contractual (i.e. private) treatment will be discussed where appropriate, but with less emphasis than the above. As has been considered infra, the contents of contractual duties in any event are very similar to their delictual counterparts.

[21]Reform is discussed infra.

proceeded apace.[22] A marked retrenchment of recent decisions from the broad principle enunciated by Lord Wilberforce in Anns v. London Borough of Merton[23] has taken place.[24] The House of Lords has held that whether a duty of care exists in a case of auditors' negligence should be determined by an application of adapted existing criteria rather than by general principle.[25] Any narrowing trend,[26] however, has been independent of developments[27] in areas of

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[22]See the opinion of Lord Scarman (giving the opinion of the court), in Tai Hing Ltd. v. Liu Chong Hing Bank Ltd. and Others [1986] 1 A.C. 80 (P.C.), at p. 101C et seq. See also discussion, including the tort/contractual duties debate, in ch. XI (Contractual Duties Not Fixed by the Parties), An Introduction to the Law of Contract, P. S. Atiyah, fourth edition, Clarendon Press, 1989.

[23][1978] A.C. 728, per Lord Wilberforce at pp. 751-752

[24]See inter alia Tai Hing Cotton Mill Ltd. v. Liu Chong Hing Bank Ltd. and Others [1986] 1 A.C. 80 (P.C.), Murphy v. Brentwood District Council [1990] 3 W.L.R. 414, Governors of the Peabody Donation Fund v. Sir Lindsay Parkinson and Co. Ltd., [1984] 3 W.L.R. 953, H.L. and also, The Modern Law of Negligence, R. A. Buckley, Butterworths, 1988 at pp. 3-12; Clerk and Lindsell on Torts, sixteenth edition, Sweet and Maxwell, 1989, ch. 10 ("Negligence", R. W. M. Dias and A. Tettenborn) at pp. 444-455, discussing inter alia Anns (supra) and liability for economic loss.

[25]Caparo Industries plc v. Dickman and others, [1990] 1 All E.R. 568. For a comparison of the factors to be taken into account, including contractual aspects, in a principal-contractor/engineer-subcontractor relationship, see Pacific Associates Inc. and Another v. Baxter and Others, [1989] 2 All E.R. 159 (C.A.).

[26]Discussed generally in, Rethinking Negligence: The House of Lords and the Duty of Care, J. G. Logie, 1988 S.L.T. (News) 185.

[27]For example as to what constitutes a Crown body and the extent of its immunity from common law remedies (and indeed from statutory intervention). The British Medical Association succeeded in its appeal to the House of Lords on a narrow question of an interdict against Greater Glasgow Health Board:

negligence in which the existence[28] and/or nature[29] of the duty of care is not in issue. By contrast, in the law of medical negligence, liability has been extended to some extent by the development of new facets of the duty of care,[30] although the existing test for the standard of care

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British Medical Association v. Greater Glasgow Health Board 1989 S.L.T. 493. For an analysis of this case, and inter alia the similar case of Lord Advocate v. Strathclyde Regional Council 1990 S.L.T. 158, see Crown Immunity from Statute, I. S. Dickinson, 1990 S.L.T. (News) 61.

[28]See Johnstone v. Traffic Commissioner 1990 S.L.T. 409, discussing the liability of a senior medical officer in giving advice to the Commissioner. The case envisages that a duty of care to third parties, however, might exist in suitable circumstances. See also Weir v. J. M. Hodge & Son 1990 S.L.T. 266 (O.H.) in which the Outer House held, being bound by an earlier House of Lords decision, that a solicitor did not owe a duty of care to a beneficiary in respect of a will which he had been instructed to prepare (another aspect of the duty owed by solicitors is considered in: Are Solicitors Liable for Counsel's Negligence? A.R.W. Young, 1990 S.L.T. (News) 177).

[29]See Moyes v. Lothian Health Board 1990 S.L.T. 444 (O.H.). Interestingly, the duties applicable to the Secretary of State acting through the Scottish Home and Health Department in respect of public health vaccination programmes have been reconsidered in a similar case to Bonthrone v. Secretary of State for Scotland 1987 S.L.T. 34. In Ross v. Secretary of State for Scotland 1990 S.L.T. 13, Lord Milligan held that in the absence of averments of bad faith a case based on negligence in a policy-based decision must fall. An associated question was raised in Montgomery v. Lothian Health Board and Secretary of State for Scotland, unreported, Outer House, 8 February 1989, in which it was averred that a duty existed to warn the natural mother of an adopted child not to have the child vaccinated where an adverse result occurred allegedly as a result whooping cough vaccination. A proof before answer was allowed by Lord Morton of Shuna (i.e. confirming the competency and relevancy of the averments if proven) on the question of the location and circumstances of the vaccination.

[30]E.g. Gerber v. Pines, (1934) Solicitors' Journal 13. See also Chapman v. Rix, Times, 19 November 1959 and 22 December 1960, and Coles v. Reading and District Hospital Management Committee, (1963) 107 Solicitors' Journal 115. See also Fowler v. Greater Glasgow Health Board 1990 S.L.T. 303, concerning the provision of information by medical staff to parents following

has not been altered.[31] [32] Rather, it has continued to be applied without relaxation.[33] It could be argued, perhaps by economic analysts of law,[34] that the fundamental nature of the doctor/patient relationship is contractual, postulating the absence of the National Health Service. On this view, the usual, delictually-governed relationship resulting from the existence of the Service represents an aberration. The present writer, however, seeks to discuss

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brain damage sustained whilst in hospital and whether an inference of negligence could be drawn.

[31]See Ingram v. Ritchie, unreported, Outer House, 28 July 1989 (failure to warn 35 year old smoker of risks inherent in short-term use of low-dose contraceptive pill; patient subsequently suffered thrombosis). In Brady v. Brown, unreported, Outer House, 5 July 1988, the test for the standard of care laid down in Hunter v. Hanley 1955 S.L.T. 213, 1955 S.C. 200 was applied, and the applicability of the test to different clinical settings considered. It is disappointing that this case has not, so far as the writer is aware, been reported.

[32]Johns v. Greater Glasgow Health Board 1990 S.L.T. (Notes) 459; Goorkani v. Tayside Health Board, 1991 S.L.T. 94 (failure to advise on risk of infertility following unconnected eye treatment); Gibson v. Grampian Health Board, unreported, Outer House, 15 March 1985 (failure to remove cannula and associated ducting postoperatively).

[33]See inter alia Moyes v. Lothian Health Board 1990 S.L.T. 444; also Devaney v. Greater Glasgow Health Board, unreported, Outer House, 30 January 1987.

[34]See generally Calabresi, The Costs of Accidents, Yale University Press, 1970. However, Walker (on Delict, second edition, 1981 at p. 1057) has commented that a contract "may" be formed where a patient consults a National Health Service doctor. With the greatest respect, it is doubted whether this is the appropriate view. This is discussed elsewhere.

the most commonly-presenting example, that of the National Health Service patient.[35]

It is axiomatic that the clinical context in which medical negligence arises is highly relevant to a consideration of the standard of care. Since 1948 most medical consultations have been obtained under the National Health Service.[36] [37] Where a patient does consult a doctor privately, the terms of that contract may expressly agree (unusually) that treatment, for example, will be successful,[38] thus grounding an action for breach of

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[35]This thesis is an inappropriate place for a debate upon the merits in terms of economic analysis of the health service, a subject meriting separate and extensive treatment in itself, e.g. in Medical Malpractice, Theory, Evidence and Public Policy, P.M. Danzon, Harvard University Press, 1985, especially chapters 1 - 4 and Part II.

[36]National Health Service Act 1948; see also National Health Service (Scotland) Act 1978.

[37]Assuming that it provides a valid basis, figures for the number of beds allows some comparison to be made. The private sector provides relatively little in terms of long-stay as opposed to acute services, for obvious reasons. Nevertheless, it is still likely that the public sector is far bigger than the private. See Health in Scotland, H.M.S.O., Scottish Home and Health Department, 1987 (the most recent available at the time of writing) ch. 2, and Independent Hospitals Association Acute Hospital Survey, Introduction, 1989 (from private communication to the author): a growth in this part of the private sector since 1979 of a 37% increase in beds to 10,433 is reported for the U.K. In Scotland alone, however, the increase reported is from 265 to 398 beds over the same period. This represents an increase of 50%. Health in Scotland records 55, 338 beds for the National Health Service in 1987, at p. 23 (see caveat above).

[38]Implied terms are relatively little discussed in the case law. It seems that the courts will be slow to imply terms significantly more onerous than their tort/delict-based counterparts. This is exemplified by Thake v. Maurice, [1986] Q.B. 644 and Eyre v. Measday [1986] 1 All E.R. 488.

contract where this is not fulfilled.[39] However, as considered above, it is submitted that the case law suggests that the contents of the tests for medical negligence in contract and tort/delict are still converging.[40] Partly, this is for the practical reason that a private patient may sue concurrently in contract and in tort or delict: the contractual terms which the (English) courts have seen fit to imply have been similar in effect to the tortious standard of care.[41] [42]

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[39]See Morris v. Winsbury-White [1937] 4 All E.R. 494. In addition, contract terms may be affected by the Supply of Goods and Services Act 1982 (now modified by the Consumer Protection Act 1987) and the Unfair Contract Terms Act 1977. For discussion, see The Doctor and the Supply of Goods and Services Act 1982, A.P. Bell, 1984 4 Legal Studies 175, and The Unfair Contract Terms Act, A Revolution in the Law of Contract, M.G. Clarke, 1978 S.L.T.(News) 26 and 33.

[40]Robertson v. Bannigan 1965 S.L.T. 66 supports this proposition. It appears to be the case generally in the matter of professional negligence. See Jackson and Powell, Professional Negligence, third edition, Sweet and Maxwell, 1992, at p. 7 et seq. See also inter alia Esso Petroleum Co. Ltd. v. Mardon, [1976] Q.B. 801 per Master of the Rolls (at p. 819); Midland Bank v. Hett, Stubbs & Kemp [1979] Ch. 384. In Scots law, Edgar v. Lamont 1914 S.C. 277 suggests that the two bases of liability co-exist: "(I)t seems to me that the clear ground of action is that a doctor owes a duty to the patient, whoever has called him in and whoever is liable for his bill, and it is for breach of that duty that he is liable, in other words, that it is for negligence arising in the course of the employment, and not in respect of the breach of contract with the employer", per Lord Salvesen, 1914 S.C. at pp. 279-280. In Edgar, a husband had called in the doctor, who defended an action against himself by the patient (wife) because of absence of title to sue in contract. This defence failed.

[41]Morris v. Winsbury-White, [1937] 4 All E.R. 494; Thake v. Maurice [1986] Q.B. 644; Eyre v. Measday [1986] 1 All E.R. 488.

[42]There are other suggestions, mainly obiter, to this effect. See also Stevenson v. Shafer, 1953 S.L.T. (Sh. Ct.) 107. "Even in contract...the plaintiff must prove a loss of substance..."; Hotson v. East Berkshire Area Health Authority

It is trite that the professional nature of medical practice, and in turn forensic consideration of its negligent exercise, entails that an ordinary man in the Clapham omnibus is not appropriate to pronounce on matters of medical treatment. This is well recognised by the law. In the general case, the more appropriate test is that of the "ordinary medical practitioner on the Clapham omnibus".[43] If, however, that test were of wide application, it is less so now: this is because of the relentless march of specialisation.[44] It is now commonly the case that, unless dealing with a general practitioner, expert witnesses must be selected by the pursuer's solicitor from the long list of hospital specialties.[45] In complex cases, perhaps involving a condition which could

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(Court of Appeal), per the Master of the Rolls, Donaldson M.R., [1987] 2 W.L.R. 287 at p. 295d; also Lord Dillon, ibid., at p. 298g; see also the (obiter) opinion of the Master of the Rolls in Naylor v. Preston Area Health Authority, [1987] 1 W.L.R. 958 at p. 967g-967h: "[I]n my judgment...it is but one aspect of the general duty of care, arising out of the patient-medical practitioner or hospital authority relationship and gives rise to rights both in contract and tort".

[43]The metaphor used by McNair J. in Bolam v. Friern Hospital Management Committee [1957] 1 W.L.R. 582.

[44]"Today the fund of medical knowledge is so vast, and increasing at such a rate, that no one practitioner can master all aspects of medical care." The Organization of Health Care: A Critical View of the 1974 Reorganization of the National Health Service, by P. Draper, G. Grenholm and G. Best, p. 254, ch. 8 in An Introduction to Medical Sociology, ed. D. Tuckett, Tavistock, 1976.

[45]This may be more problematic than may appear. See pp. 139-142 of Preparation of Medical Evidence on Liability, A. Winyard, ch. 8 in Medical Negligence, M. J. Powers and N. H. Harris, Butterworths, 1990.

arise either from the anaesthetic or operative procedure, even identifying and distinguishing the crucial issues to be litigated may be difficult for the pursuer's advisers.[46]

The body of professional knowledge, which arguably distinguishes all professional[47] from other liability in negligence,[48] entails the shape of the present action's emphasis upon expert testimony.[49] Jackson and Powell comment that,

> "[T]he problem which the courts have faced in devising a rational approach to professional liability, is that they must provide proper protection for the consumer, whilst allowing for the factors mentioned in the previous paragraph. Broadly speaking, the solution which has been found is to require that professional men should possess a certain minimum degree of competence

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[46]This factor combines potently with another to enhance the effect of the expert witness: judges are not medically trained, although they have expertise in assimilating and evaluating expert testimony.

[47]mutatis mutandis

[48]But what exactly is a profession? This is another determinant of the standard to be applied. A test of "holding out" was applied in relation to a dental practitioner in Dickson v. Hygienic Institute, 1910 S.C. 352. This approach was broadly followed in Kirkcaldy District Council v. Household Manufacturing Ltd., 1987 S.L.T. 617: a solid fuel advisory service was held not to be "holding themselves out to be acting as a member of what the courts have as yet understood to be a "professional class" of adviser" (per Lord Allanbridge, 1987 S.L.T. at p. 622). This less-strict test implied for the non-profession tends to follow the approach in Morrison's Associated Companies v. James Rome & Sons Ltd. 1964 S.C. 160. For discussion of this point, see p. 572, Responsibility for Negligence, J.W.G. Blackie: chapter in Medical Responsibility in Western Europe, ed.s. E. Deutsch and H.-L. Schreiber, Research Study of the European Science Foundation, Springer-Verlag, Berlin, 1985.

[49]This is so irrespective of which of Howie's or Norrie's views is preferred.

> and that they should exercise reasonable care in the discharge of their duties."[50]

It is this common law duty that is central to this discussion, representing the most common, and debated, aspect of the standard of care.[51] The uncertainty with which the test for the standard of care requires to deal may be analysed into several components. Those of consumer protection and individual judgment have already been identified. Intermixed with these are variations in doctors' abilities, values, and differing patient expectations and outcomes.[52] Since at least 1838, it has been recognised that "...nor does a surgeon undertake that he will perform a cure; nor does he undertake to use the highest possible degree of skill".[53]

Hunter v. Hanley

It is reconciliation of these conflicting requirements that has been attempted by the modern formulation of the test

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[50]Professional Negligence, R.M. Jackson and J.L. Powell, third edition, Sweet and Maxwell, 1992, p. 5.

[51]The statutory duties, such as those arising under the Consumer Protection Act 1987, Mental Health (Scotland) Act 1984 and Vaccine Damage Payments Act 1979, merit a more substantial treatment than is possible in a thesis dealing primarily with the common law. Readers are therefore referred to the literature on these subjects.

[52]Such factors may well influence the likelihood of there being litigation in the first place.

[53]Tindall C.J., in Lanphier v. Phipos (1838) 8 C. & P. 475 at p. 478.

for the standard of care. The leading Scottish case, Hunter v. Hanley,[54] involved the negligent use of too small a bore of needle for an intramuscular penicillin injection. The needle broke and lodged in the pursuer, causing her injury and distress. It was argued for the pursuer that the doctor had fallen below the required degree of care. At trial, it was held that the test was whether there was such a departure from usual practice as could reasonably be described as gross negligence. On appeal, however, the dispute consequent upon reference to gross negligence was largely resolved.[55] Following judicial consideration of the appropriate standard, a new trial was ordered.

The leading opinion was delivered by Lord President Clyde, and remains strong authority today. At the outset, it may be mentioned that although the precise type of injection in Hunter may not be the most common, it is an example of a minor procedure universal to medical practice. Because of this, and the frequency of giving injections by medical personnel, it is thought that there is relatively little room for variation in technique consistent with non-negligent practice. If this is so, a consequence is that

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[54]1955 S.C. 200

[55]The full resolution of this point, as it has subsequently been argued outwith the courts, has been left to R.B.M. Howie and K. McK. Norrie, in The Standard of Care in Medical Negligence, 1983 J.R. 193, and Common Practice and the Standard of Care in Medical Negligence, 1985 J.R. 145 respectively. The present writer takes the view that the test does not involve the establishment of gross negligence. This is a point advocated by Norrie.

there is little scope for genuine difference of professional opinion in performing such tasks, and hence that the use of an undersized needle is hardly an example of deviation from common practice. As a result, on the facts of Hunter, either evidence of common practice would exert a disproportionately strong effect, or it was a case merely of incompetent performance of a standard technique. The previous cases to which reference was made in the opinions did raise the issue of gross negligence; it may be that the arguably idiosyncratic aspects of the facts in Hunter also impelled judicial consideration of this. Resolution of the question was not, however, dealt with wholly unequivocally by the Lord President.[56] He considered both Glegg on Reparation[57] and the previous case-law. The latter concerned mainly the liability of solicitors in negligence to their clients, discussing gross negligence.[58] His approach distinguished medical (in the context of

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[56]See The Standard of Care in Medical Negligence, R.B.M. Howie, supra, and Common Practice, and The Standard of Care in Medical Negligence, K. McK. Norrie, supra.

[57]Third edition, at p. 509: see opinion in Hunter v. Hanley 1955 S.C. 200.

[58]See the opinion of Lord President Clyde, Hunter v. Hanley, 1955 S.C. 200, discussing previous authorities at p. 205. He mentions Farquhar v. Murray (1901) 3 F. 859, a medical negligence case which turned wholly on its facts. He also referred to a series of decisions concerning the negligence of law agents in advising their clients. The cases to which he refers included Hart v. Frame & Co., (1839) McL. and Rob. 595, Purves v. Landell, (1845) 4 Bell's App. 46 and others. His Lordship summarises their effect as being that errors in interpreting the law, or in knowledge of the law, do not per se constitute negligence.

"professional") negligence from other forms of negligence. This was because of the "ample scope for genuine difference of opinion".[59] However, these authorities provided little satisfactory guidance on the question of gross negligence. The apparently most relevant case, Farquhar v. Murray,[60] turned entirely upon issues of fact. Practically no discussion of the law is reported. Nor did the edition of Glegg referred to by his Lordship vouchsafe significant support for a test of gross negligence in cases of medical negligence.

However, negligence in that degree was certainly extant elsewhere in the law of delict. The cases involving trustees concerned an "immunity" clause, and it may have been this which partly impelled the development of the law towards an additional standard of gross negligence in this area.[61] If so, this specialty of the constitution of trustees' powers scarcely merited its transplantation into the law of medical negligence. Some degree of indirect support for this suggestion may be gleaned from Menzies on

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[59]Per Lord President Clyde, Hunter v. Hanley, 1955 S.C. 200 at p. 204.

[60](1901) 3 F. 859

[61]The cases referred to by Lord President Clyde, at 1955 S.C. 200 at p. 205 include Knox v. McKinnon (1888) 15 R. (H.L.) 83; Raes v. Meek, (1889) 16 R. (H.L.) 31; Carruthers v. Carruthers, (1896) 23 R. (H.L.) 55 and Wyman v. Paterson (1900) 2 F. (H.L.) 37.

Trustees,[62] which reviewed the law of trustees' negligence a few years after the cases which the Lord President cited occurred. Menzies states that gross negligence is required in order to render a trustee liable, but that "simple negligence" is insufficient.[63] Wilson and Duncan on Trusts, Trustees and Executors also refer to a two-tier analysis of trustees' negligence, against which an immunity clause only confers protection in the case of ordinary negligence, or errors of judgment, although much depends upon the wording of the clause.[64]

Regarding professional negligence, Lord President Clyde said that he regarded the phrase, " "gross negligence" only as indicating so marked a departure from the normal standard of conduct of a professional man as to infer a lack of that ordinary care which a man of ordinary skill would display. So interpreted, the words aptly describe what I consider the sound criterion in the matter, although, strictly viewed, they might give the impression

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[62]The Law of Scotland affecting Trustees, A. J. P. Menzies, second edition, W. Green, 1913, ch. 5 (The Execution of Trust), para(s). (511 and) 512 et seq.

[63]"Where there is a want of exact diligence-the omission to execute some trust modo et forma - such negligence will be covered by the immunity. Where there is a want of simple diligence-the omission even to attempt to execute some trust-such negligence is gross; it is culpa lata, and the immunity does not apply." Menzies on Trustees, op. cit., at para. 512, p. 279. See also Menzies, op. cit., footnote 1 at pp. 279-280.

[64]Trust, Trustees and Executors, W. A. Wilson and A. G. M. Duncan, with W. A. Elliott, S.U.L.A./W. Green, 1975, at pp. 390-391, considering several clauses which have come before the courts.

that there are degrees of negligence."[65] This suggests that the Lord President equiparated the substance of the two apparently discrete types of negligence,[66] which would appear to reflect the contemporary approach to the standard of care in negligence generally.[67] The standard of "ordinary" skill and care, employed by the Lord President has given rise to much debate within the context of medical negligence:

> "[I]t follows from what I have said that in regard to allegations of deviation from ordinary professional practice - and this is the matter with which the present note is concerned - such a deviation is not necessarily evidence of negligence. Indeed it would be disastrous if this were so, for all inducement to progress in medical science would then be destroyed...[T]o establish liability by a doctor where deviation from normal practice is alleged, three facts require to be established. First of all it must be proved that there is a usual and normal practice; secondly it must be proved that the defender has not adopted that practice; and thirdly (and this is of crucial importance) it must be established that the course the doctor

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[65]Hunter v. Hanley, cit. sup., per Lord President Clyde, at p. 206.

[66]See, The Standard of Care in Medical Negligence, R.B.M. Howie, supra; per contra, Common Practice and the Standard of Care in Medical Negligence, K. McK. Norrie, supra. However, in the light of recent case-law, it has been argued that the English law and Scots law approaches to the standard of care in medical negligence are diverging: see Medical Negligence, Hunter v. Hanley 35 Years On, anon., 1990 S.L.T. (News) 325.

[67]Walker states that, "[T]he distinction between culpa lata, culpa levis and culpa levissima is no longer generally accepted in Scotland, [he cites as authority for this proposition Ersk. III, 1, 21; S.S. Baron Vernon v. S.S. Metagama, 1927 S.C. 498 per Lord Justice Clerk Alness at p. 509 and even Hunter v. Hanley, cit. sup.] but the duty to take reasonable care is infinitely variable according to the circumstances of the case." The Law of Delict in Scotland, D. M. Walker, second edition, 1981, W. Green, at p. 200-201.

> adopted is one which no professional man of ordinary skill would have taken if he had been acting with ordinary care."[68]

The long-established standard of care at Scots common law is based upon the "reasonable man".[69] Whether the Lord President's formulation, using the word "ordinary" in preference to "reasonable", represents a difference in substance, has occasioned some debate. Walker considers that the two are similar:

> " " "[R]easonable care" is therefore what is reasonable for a qualified member of that trade or profession, [he cites Lanphier v. Phipos (1838) 8 C. & P. 475] such failure as no doctor of ordinary skill would be guilty if acting with ordinary care" [per Lord President Clyde in Hunter v. Hanley, cit. sup., p. 205]....[I]n such cases [medical] deviation from usual and normal practice is negligence only if the course of action adopted is one "which no professional man of ordinary skill would have taken if he had been acting with ordinary care" [per Lord President Clyde, Hunter v. Hanley, cit. sup., p. 205]." "[70]

Norrie argues that the two standards are different:

> "...[A] test of "reasonable care" necessarily carries with it a connotation which allows the court to say what ought to have been done in the circumstances; which connotation is lacking on a strict definition of "ordinary care", which suggests reference only to average or usual standards, and so binds the court to accept as not being negligent that which is ordinarily done in the circumstances of the case."[71]

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[68]Per Lord President Clyde, Hunter v. Hanley 1955 S.C. at p. 206.

[69]For example, Muir v. Glasgow Corporation 1943 S.C. (H.L.) 3, and Walker on Delict, cit. sup., at pp. 199 - 206.

[70]Walker on Delict, cit. sup., at pp. 205-206.

[71]Common Practice and the Standard of Care, K. McK. Norrie, 1985 J.R. 145, at p. 148.

He comments further that evidence of similar practice by other, average, doctors will therefore constitute an absolute defence.[72] It therefore seems that the test for negligence set out in Hunter was a departure from the more traditional test of reasonable care used generally in the law of delict. Returning to the test itself, if the extent of the deviation is, as was said, immaterial,[73] this might appear to be inconsistent with the general disavowal of differing degrees of negligence.[74] This appearance would not be so, however; he argues that the existence of deviation is the important factor, not its extent. Norrie's point regarding the weight of evidence of common practice - even by a single other practitioner - must also be borne in mind.[75] However, it has recently been argued that the English approach to the test for medical negligence, as expounded and subtly varied in cases such as Sidaway v. Governors of the Bethlem Royal Hospital,[76] has

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[72] ibid.

[73] Per Lord President Clyde, Hunter v. Hanley, 1955 S.C. 200 at p. 206.

[74] Ibid., at p. 206, although the Lord President does say that "strictly viewed" his words might be taken to indicate differing degrees.

[75] Common Practice and the Standard of Care in Medical Negligence, K. McK. Norrie, supra.

[76] [1985] 1 All E. R. 643

now diverged from that in Scotland, to a less clear standard.[77]

Lord Russell ventured to add to Lord President Clyde's opinion only in relation to the jury's construction of Lord Patrick's charge at the trial.[78] However, he too canvassed the question of a standard of "gross negligence". As far as the cases dealing with the immunity of trustees, and their use of the more serious standard, was concerned, he drew attention to the fact that the trustees concerned were non-professional, gratuitous trustees. By this means, he at the very least implicitly distances his views from the more stringent standard.[79]

Lord Sorn referred firstly to Farquhar v. Murray[80], as the only case involving a doctor to which the court's

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[77]Medical Negligence (Hunter v. Hanley 35 Years On), Anon., 1990 S.L.T. News, 325. The present author respectfully disagrees with this view, on the basis that the Scottish cases appear to apply a test of the same substance as the English. The debate in the pages of the Juridical Review between K.McK Norrie and R.B.M. Howie, considered elsewhere, suggests that the substance of the tests (in the mid-1980s) was similar. A rebuttal of this argument has also been published by D.K. Feenan in Medical Negligence: Hunter v. Hanley 35 years on: a reply, 1991 SLT (News) 321, with which the present author would respectfully agree.

[78]Ibid., at pp. 206-207.

[79]Opinion of Lord Russell, Hunter v. Hanley, 1955 S.C. 200 at pp. 206-207. However, D. M. Walker quotes without comment, but with implicit approval, Lord Russell in Hunter when the latter said: " "There is...only one standard, viz., the absence of reasonable care in the circumstances, or ordinary culpa" " [Lord Russell, ibid., at pp. 206-207]. Quoted in The Law of Delict in Scotland, D. M. Walker, second edition, W. Green, 1981, at p. 200.

[80](1901) 3 F. 859.

attention was drawn. He was clearly of the view that the case was equivocal authority for any proposition regarding the standard of care.[81]

He commented that it was assumed generally that the standard of gross negligence in the cases involving law agents suggested, by analogy, that that standard should be applied to cases of medical negligence.

> "It may be said, however, that, until recent times, the general impression has been that gross negligence must be proved in order to render a doctor liable. The impression has been derived from decisions and dicta pronounced in cases relating to solicitors."[82]

However, his Lordship concluded that such an approach should not necessarily apply to doctors. In the light of the decisions inter alia in Stevenson v. Donoghue(sic)[83] and Caswell v. Powell Duffryn Associated Collieries,[84] he considered that there probably was not room for a test involving gross negligence and in any event appeared to doubt whether the authorities dealing with law agents

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[81]"..[A]ll that was decided was that the case was relevant for enquiry, two of the Judges indicating that "gross negligence" must be proved and the other two not committing themselves on the matter." Lord Sorn, ibid., at p. 207.

[82]Opinion of Lord Sorn, Hunter v. Hanley, 1955 S.C. at p. 207.

[83]1932 S.C.(H.L.) 31

[84][1940] A.C. 152

should be regarded as of automatic applicability to the medical profession.[85] [86]

The test laid down in Hunter is still that used in modern Scots cases.[87] In England, a similar test was applied in Bolam v. Friern Hospital Management Committee,[88] although subsequent English cases have, it has been argued, ignored Hunter on occasion and diverged from its formula.[89] However, it is submitted that the subsequent case-law has continued to apply the same test.

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[85]"I think that these and other cases have resulted in a development which makes it doubtful whether, in a question of civil liability such as we have here, there remains any room for the conception of "gross negligence" as distinct from "negligence"...Whether it is lack of skill that is alleged, or lack of diligence, or both the defender must not be judged by too high a standard and I endorse what your Lordship has said on this matter." Opinion of Lord Sorn, Hunter v. Hanley, 1955 S.C. at p. 208.

[86]Lord Sorn does not consider the cases dealing with trustees' negligence, but perhaps he may also be taken to agree that they might be distinguished upon the ground that an immunity clause was the main issue in them.

[87]Indeed, a recent attempt in the Court of Session to argue that inter alia the case of Sidaway v. Bethlem Royal Hospital Governors [1985] A.C. 871 had changed the test set out in Hunter was rejected by Lord Caplan, in Moyes v. Lothian Health Board 1990 S.L.T. 444 in which the Hunter test was affirmed, per his Lordship at p. 449G - I. It has, however, been argued that the Scottish and English tests for medical negligence are now diverging: see Medical Negligence: Hunter v. Hanley 35 years on, (Anon.), 1990 S.L.T. 325; cf. D.K. Feenan, supra.

[88][1957] 2 All E. R. 118

[89]Medical Negligence: Hunter v. Hanley 35 years on, supra.

Hunter v. Hanley: Discussion

The substance of the Hunter test may, it is submitted, be divided into two analytical categories. The first is the intrinsic nature of the test itself, and the second is the legal context in which the test is applied - notably the division of responsibility of medical personnel and vicarious liability. The aim of the present section is to attempt to identify the most important of these. Whether these are indeed satisfactory, and the threshold question of whether fault is an appropriate or indeed workable touchstone of liability, will be dealt with infra.

The principal intrinsic characteristic of the test in Hunter is that only one other doctor of ordinary skill need be prayed in aid of the defender in order to exculpate him from a potential finding of negligent conduct. Although this appears lenient to the defender, in that evidence of the practice of only one other colleague need be led, it is qualified by the requirement that he be of ordinary skill. A substantial degree of emphasis is therefore placed upon evidence of common practice.

A maverick or unethical practice indulged in even by a minority of one doctor could be struck at by evidence that such was not the practice of one of ordinary skill. It should also be noted that the a doctor may practice at a far higher level of skill or ethics than the "ordinary

skill" yardstick. Although unlikely to be litigated, technically such a doctor would be in breach of the test if no other doctor of ordinary skill practised at his high standard. No explicit mechanism inheres in the test to deal with such a situation. As a practical matter, were such a case to arise, no doubt an exceptionally high standard would emerge - and be recognised as such - during expert evidence. This leads to a further point: that the test is set at the level of competence of the "ordinary" practitioner, although in construing that adjective a court could also incorporate a factor of "reasonableness".[1]

So far as the legal context of the test is concerned, it is principally the doctor who had direct contact with the patient in the "medical encounter"[2] who is liable. Leaving aside cases in which a "team" or "post" test has been canvassed,[3] this takes no account of the present structure of Health Service medical personnel[4] and the

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[1]See The Standard of Care in Medical Negligence, R.B.M. Howie, cit. sup. and Common Practice and the Standard of Care in Medical Negligence, K. McK. Norrie, cit, sup.

[2]I.e. whether diagnosis, treatment or consent etc.

[3]Even in these cases, the test for medical negligence (and causation connection) has been applied to the actual medical practitioner who performs the treatment or who dealt with the patient: Wilsher v. Essex Area Health Authority [1986] 3 All E. R. 801 (C.A.) and [1988] 1 All E. R. 871 (H.L.).

[4]Edgar v. Rosen, 7 May 1986, 1986 293 B.M.J. 552. No doubt part of the underlying rationale for this is as expressed by Stair, in a somewhat theological vein at times: "[T]he obligation of delinquence then, is that what whereunto injury or malefice doth oblige, as the meritorious cause thereof....

"In reference to man is the obligation of repairing his damage, putting him in as good condition as he was before the

division of clinical responsibility. In such a context, the one in which most reported cases arise, a consultant medical practitioner is in charge and responsible in the organisational hierarchy, although not usually and directly in law.[5] This is not reflected in the present law of medical negligence. By contrast, by virtue of the current organisation of practices into partnerships, principals in private practice as solicitors (and indeed N.H.S. general medical practitioners in partnerships) are legally responsible for the delicts of their junior professional colleagues, by the doctrine of vicarious liability inherent in the employer/employee relationship and in the joint and several liability of partners. So far as N.H.S hospital doctors are concerned, employer's vicarious liability applies, to the effect of rendering the employing health board or authority liable for employees' delicts.[6] It may be that this does not reflect the de facto responsibility of those involved, especially in view of the effective delegation of this responsibility for medical management to

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injury; and this only is man's part for himself. For the inflicting of punishment is for God, in so far as it is authorized or allowed by him; but it is not for, or from, man himself....": Viscount Stair, The Institutions of the Law of Scotland, ed. D. M. Walker, The University Presses of Edinburgh and Glasgow 1981, I, 9, 2.

[5]Unless perhaps improper delegation has taken place, for example.

[6]Discussed above in the context of the basis of liability: N.H.S. Trust-status hospitals are themselves responsible for payment of claims in respect of medical negligence.

the consultant in charge of the case.[7] Research has shown that although the rate of deaths in surgical operations generally is acceptably low, nevertheless this tends to hide unsatisfactory practices, which may well not result in death or even any harm at all. One of these factors, albeit not necessarily congruent with legal "fault", has been unsatisfactory supervision of, and by implication over-delegation to, junior doctors by consultants.[8] The weight to be ascribed to evidence of common practice has been vigorously debated by Howie and Norrie.[9] In Howie's discussion, this is prefaced by a consideration of the standard of care in the Scots as well as the English law of medical negligence. The former argues that the content of the standard differs in the two jurisdictions. Whereas Hunter bespeaks an "ordinary" standard, in which evidence

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[7]See Edgar v. Rosen, supra. See also the reference to the Report of a Confidential Enquiry into Perioperative Deaths, infra.

[8]The Report of a Confidential Enquiry into Perioperative Deaths, N. Buck, H.B. Devlin and J.N. Lunn, The Nuffield Provincial Hospitals Trust and The King's Fund, 1987: "[O]ur assessors are similarly concerned that many operations were undertaken by surgeons too junior and too inexperienced to do the job. Assessors commented that mistakes were frequently made by these surgeons....[T]his lack of supervision in many cases has led our assessors to recommend that no patient should undergo a surgical operation without prior consultation being obtained by the operating surgeon with the consultant on duty or his senior registrar." (p. 38). The broad findings of this study have been confirmed by the second report, considered infra in the context of reform.

[9]The Standard of Care in Medical Negligence, R.B.M. Howie, supra; Common Practice and the Standard of Care in Medical Negligence, K. McK. Norrie, supra.

of common practice plays a largely determinative role, the English case of Bolam[10] apparently differed in that a higher standard, of conformity with a responsible body of opinion, must be established in order for the doctor to avoid liability.

The English Approach

In Bolam, the patient had been admitted to hospital for treatment by E.C.T., or electro-convulsive therapy. Although he was suffering from a mental illness, he was sufficiently capax as to be able to give consent by signing a form. He did this in ignorance of the risks inherent in the treatment, particularly that of fractures as a result of muscular contractions. Evidence was led to the effect that the probability of this event occurring was one in ten thousand. Consequent upon the administration of this treatment, Bolam suffered serious pelvic fractures. It further emerged in evidence that there were two responsible schools of opinion on the risks of administering this type of treatment. They were opposed on the issue of whether the patient should be given relaxant drugs or whether manual control of the patient should be applied. The action against the hospital's management committee was both in respect of the lack of information given to the patient

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[10]Bolam v. Friern Hospital Management Committee, [1957] 2 All E. R. 118.

in order to obtain his consent[11] and that some form of relaxant drug should have been administered. Broadly, it was clear from McNair J.'s charge to the jury that the doctor should not be held guilty of negligence merely because he conforms with a responsible body of medical opinion which takes a conflicting view to that of a different but also respectable body of medical opinion.

The question at issue thus was somewhat different from that in Hunter, and it is as a result of this that differing views of the test for medical negligence were possible. Howie argues that because of the emphasis upon a responsible body of medical opinion, doctors are therefore able to "legislate themselves out of the law of negligence by supporting each other's actions, however unreasonable these might appear".[12] The absence of an explicit ethical factor allowing the court to hold a common practice to be unreasonable is thus said to be a flaw in the test. However, Howie himself admits that the two early cases[13] upon which he starts his discussion provide limited support for his argument:[14]

> "...[T]hese cases are balanced by others which seem to be more in tune with the principles

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[11]Presumably consent in cases of mental illness will be particularly affected by the doctor's wish not to worry or upset a patient who perhaps already suffers from such conditions.

[12]Howie, op. cit., at p. 201.

[13]Lanphier v. Phipos (1838) 8 Car. and P. 475 and Rich v. Pierpont (1862) 3 F. and F. 35.

[14]Howie, op. cit., at p. 203.

> enunciated in Lanphier, Rich and Bateman. Since the early 1950s there have been cases in which the court has itself fixed the standard of care to be attained, and fixed that standard on the basis of what it conceives ought to have been done in the circumstances of the case litigated. The expert evidence as to medical practice has not been treated as conclusive on the issue of negligence."[15]

However, Howie considers the Scots law to differ from this. This view is based substantially upon his analysis of the Lord President's opinion in Hunter, which he argues omits the so-called ethical or reasonable dimension allowing the court to superimpose its own standards upon the profession where required. He also views the Lord President's opinion as supporting the proposition that the test for medical negligence in Scots law is one of gross negligence.[16] The essence of his argument appears to be that the Lord President equates similar practice with common practice. By contrast, the view put forward in Howie's article is to the effect that a common practice is one carried on by a reasonably large number of practitioners, whereas a similar practice refers to one carried on by a few or even one or two practitioners.[17] The thrust of the argument against the Lord President's test is that the two types of practice are wrongly equated; the effect of common practice is thus devalued. It is argued from this that because evidence of

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[15]Howie, op. cit., at p. 207.

[16]Howie, op. cit., at pp. 211-213; see also p. 215.

[17]Howie, op. cit., at pp. 213-216.

only one other doctor's like practice suffices to prevent a finding of negligence, that the standard of care is in effect one of gross negligence: "[W]hile it may be correct to say that gross negligence is now not a term used to describe the standard, it does not follow that that standard has been departed from."[18] The cases considered by the Lord President and discussed supra are, it is suggested, consistent with this view. Two further points are advanced in order in support of this. Firstly, he mentions the comment by the Lord President that gross negligence is the "sound criterion in the matter", although the latter did explain the test and his interpretation of gross negligence in a close context.[19] Howie also draws attention to certain textual similarities between tests enunciated in inter alia Urquhart v. Grigor[20] and that of Lord President Clyde in Hunter.[21] Ultimately, the article argues that Bolam attempts to reconcile the irreconcilable, being one line of authority stressing evidence of similar practice and his view of the English test stressing reasonable care.

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[18]Howie, op. cit., p. 217.

[19]Per Lord President Clyde, Hunter v. Hanley 1955 S.C. at p. 206. See Howie, op. cit., p. 217 et seq.

[20](1857) 19 D. 853

[21]Howie, op. cit., at p. 218.

These views have been considered by Norrie.[22] He traces the adoption of the test set out in Hunter in Bolam, in which McNair J. approved it.[23] Norrie argues that the acceptance of the Bolam test in Whitehouse v. Jordan[24] indicates that the substance of the Hunter test became part of English law.[25] The standard of care is argued to be the same in both jurisdictions.[26] This being so, he continues, there is no reason for there to be a difference in the court's view of common and similar practices north and south of the border.[27] Norrie's view of inter alia Sidaway is that a standard of care consistent with that in Hunter

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[22]K. McK. Norrie, Common Practice and the Standard of Care, supra.

[23]McNair J. in Bolam strongly implies that the substance of the test is the same in both jurisdictions when he says that "[i]t is just a question of expression. I myself would prefer to put it this way: A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. I do not think there is much difference in sense." (Bolam, [1957] 2 All E. R. 118 at p. 122).

[24][1981] 1 All E. R. 267

[25]This point, Norrie says (op. cit., at p. 148) derives from J.A. Cameron's view as expressed in Medical Negligence: An Introduction, Law Society of Scotland, 1983.

[26]This is particularly because, as Norrie says, op. cit., at p. 149, the Hunter test was also approved in Maynard v. West Midlands Regional Health Authority [1984] 1 W.L.R. 634 and Sidaway v. Board of Governors of the Royal Bethlem Hospital [1985] 2 W.L.R. 480.

[27]Norrie, op. cit., at p. 152. He argues that some of the cases cited by Howie, particularly Vancouver General Hospital v. McDaniel (1934) 152 L.T. 56 (P.C.) are of insufficient width to support fully the propositions for which they are advanced as authority by Howie.

was stated by the majority,[28] and in turn that the court is able to impose its own view of what the standard of care should be.

So far as the Scots law is concerned, Norrie refers to the case of Kelly v. Edinburgh District Council,[29] in which an architect used glass in breach of a specification set out in the appropriate British Standard Code. The Inner House held that departure from the code, which was a guide to good practice, was not conclusive of negligence. This in turn raises the question as to whether a guide to practice, and the issue of professional practice are the same: it is thought, however, that they should not be equiparated. Nevertheless, Norrie's argument to the effect that the Scottish courts can and will depart from the internally-set standard does receive some support from the case. Similarly, he argues that common practice as such will not be exhaustive of issues of negligence as far as the courts are concerned. Nor, he argues, does departure from common practice produce a shift in the onus of proof to the defender, in the manner of res ipsa loquitur.[30] His view of Clark v. McLennan[31] is that it is merely an example

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[28]Norrie, op. cit., at p. 154-155.

[29]1983 S.L.T. 593

[30]Norrie, op. cit., at p. 158-160, citing inter alia the cases of Brown v. Rolls Royce Ltd 1960 S.L.T. 119 and Clark v. McLennan [1983] 1 All E. R. 416.

[31]Cit. sup.

of criticism of the heavy burden on the pursuer in cases in which the task of discharging the burden is onerous. Thus Norrie considers that Clark is inconsistent with the Lord President's test in Hunter.

In summary, Norrie seeks to demonstrate that the English and Scots law are very similar, and furthermore that both jurisdictions may hold a common practice negligent. Thus he says that the standard of care is that which the "court finds legally acceptable".[32] Despite the Lord President's use of the word "ordinary", he argues that the Hunter test did include an element of reasonableness and did not import a standard of gross negligence. This is because "ordinary" means what a doctor would do who is by implication reasonable - otherwise the word "any" would have to qualify the description of the doctor in question for the test to bear the meaning contended for by Howie. Moreover, as he comments, Lord President Clyde himself appeared to see no difference between ordinary and reasonable. Perhaps the apparent differences are merely ones of expression rather than substance.[33]

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[32]Norrie, op. cit., at p. 162.

[33]Norrie, op. cit., at p. 163. See, Raising the Standard of Care, J. Holyoak, 1990 Legal Studies 201.

Discussion

Two differing views upon the import of the test set out in Hunter have been canvassed. That case was based upon three different strands. They comprised firstly textbooks, Glegg on Reparation[34] and Salmond on Torts;[35] secondly, the previous professional negligence cases and thirdly, the cases on trustees' negligence. A primary reason for these differing views is that there was remarkably little guidance from previous medical negligence cases. Farquhar v. Murray[36] in particular, although more recent than most, was of little assistance to the court as one of the few previous medical cases discussed. Undoubtedly, the reference elsewhere in the law of delict to standards of gross negligence provided potential for arguments by analogy. This was reflected in Lord Patrick's charge to the jury in Hunter, to the effect that there "must be such a departure from the normal and usual practice of general practitioners as can reasonably be described as gross negligence".[37] However, although the rest of the charge was unexceptionable, it was on this ground that the pursuer

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[34]Third edition

[35]Eleventh edition

[36]1901 3 F. 859

[37]Per Lord Patrick in Hunter, 1955 S.C. at p. 202.

appealed; the response of the Inner House was unanimous, to the effect that this constituted a misdirection. This strongly supports the view that gross negligence was the wrong standard to import into the case. Furthermore, Howie places much emphasis upon the Lord President's opinion alone, which Norrie suggests, correctly it is thought, should be balanced by a reasonably-weighted consideration of the other opinions. By virtue of the fact that his judgment is the leading one, and is the most detailed and perhaps systematic, then some additional weighting should undoubtedly be accorded to it. But when the other opinions are also considered fully,[38] the argument in support of Norrie's view is, it is thought, strengthened. Lord Russell appears to disapprove a test of gross negligence,[39] at the same time as approving the Lord President's opinion. If there is not an inconsistency inherent in this, the conclusion must be that Lord President Clyde did not support a test based upon gross negligence. All the judges disapproved Lord Patrick's charge to the jury, making as it did express reference to gross negligence: the writer respectfully agrees with Norrie's view on this point.

So far as the difference between the two jurisdictions is concerned, prima facie there is a difference in the two tests in that McNair J. in Bolam makes express reference to

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[38]Considered supra.

[39]Hunter, 1955 S.C. at p. 206.

"reasonableness" in contrast to the "ordinary" test in Hunter. Reasonableness does connote something of a higher standard than ordinary, and perhaps with also a connotation of an external or objective yardstick. McNair J. states that,

> "I myself would prefer to put it this way: a doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. I do not think there is much difference in sense. It is just a different way of expressing the same thought."[40]

Leaving aside McNair J.'s express approval for Lord President Clyde's formulation, the issue becomes the meaning, and subsequent interpretation of, "reasonable" and "ordinary". Despite the fact that various cases from Lanphier v. Phipos[41] onwards stressed the "reasonableness" formulation, Howie tends to emphasize those apparently giving greatest weight to common practice. Norrie[42] comments, for example, that the statement relied upon by Howie, in the opinion of Lord Alness in Vancouver General Hospital v. McDaniel,[43] was obiter. However, it may be commented that that there is in effect no common ground possible between a test in which the court may displace

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[40]Per McNair J., in Bolam, cit. sup., at p. 122; quoted supra and by Norrie, op. cit., p. 148.

[41](1838) 8 Car. and P. 475

[42]Ibid.

[43](1934) 152 L.T. 56

common practice and one in which it may not. The former clearly operates a test, ultimately, of reasonableness and this must reduce evidence of common practice to the status of an evidential factor to be taken into account.

Common Practice

So far as common practice itself is concerned, it is highly desirable if not essential that the court be empowered to hold a common practice negligent if appropriate. However, there is perhaps a temptation for a court to consider that what a majority does is likely to be right, or, more accurately, at least "reasonable", and therefore that deviation is likely to be "wrong", or negligent. However, it is submitted that an unusual case may exist wherein a majority practice is negligent and the practice of the individual is not. It is partly in order to accommodate this possibility, in which the possible underlying assumption of the majority being non-negligent is false, that the court should, it is submitted, retain the potential to hold common practice negligent. It is thought that the Lord President in Hunter was aware of this when he said that,

> "...such a deviation [from ordinary professional practice] is not necessarily evidence of negligence. Indeed it would be disastrous if this were so, for all inducement to progress in medical science would then be destroyed. Even a

> substantial deviation from normal practice may be warranted by the particular circumstances."[44]

Clearly, his Lordship had in mind medical advances, rather than the (mis)use of known techniques. It is submitted, though, that what he says is in principle capable of application to the mode of performance, or choice of, an existing treatment. Again, it may be that the facts of Hunter give rise to a distorting effect: there are presumably very few if any ways in which the injection could have been performed in non-negligent deviation from the common and, in that case, non-negligent manner. Nevertheless, it may well be that deviation from a common practice would in fact raise a presumption, formal or otherwise, of negligence.[45] Nor does the test consider what the criterion for judgment should be if there is no standard practice in a particular area of medical practice.

The Standard in Differing Medical Contexts

In this section, the applicability of the test to different clinical settings will be considered in the light of Wilsher v. Essex Area Health Authority.[46] Thus far,

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[44]Lord President Clyde, Hunter, cit. sup., at p. 206.

[45]See, for example, Clark v. McLennan, cit. sup., and Wilsher v. Essex Area Health Authority, cit. sup.

[46]Cit. sup.

consideration of the test has been in the context of the actions of a single practitioner, be he a general practitioner or hospital doctor. Where more complex treatment is attempted in the context of a team of medical personnel, variations on the test have been canvassed.[47]

It may be commented that although the actual standard remains constant under the test, its content must of course vary according to the specialty, treatment setting, rank of doctor and all other circumstances of the medical encounter. Equally, it is implicit that the standard applicable to the general practitioner, as may be seen from Hunter, is that of the fellow general practitioner exercising ordinary skill, and not that of the general hospital physician, for example. In appropriate areas, this will in effect yield to a more absolute approach as where a doctor's handwriting on a prescription is illegible.[48] However, the guiding principle appears to be that of comparing like with like: an incarnation of peer review.

Wilsher v. Essex Area Health Authority

In this case, three doctors were involved in treating a neonate. They comprised the consultant in charge, the

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[47]Wilsher v. Essex Area Health Authority, cit. sup.

[48]Writing a Wrong, K. Mullan, 1988 B.M.J. 470.

house officer and senior registrar. Accordingly, the court required to consider the ascription of responsibility, which was limited to those having direct contact with the patient, rather than the consultant, in the absence of any argument of improper delegation or similar.

The infant plaintiff was born prematurely and placed in a special baby-care N.H.S. hospital unit. A junior hospital doctor inserted a blood oxygen tension monitoring catheter into his umbilical vein. It should have been into his umbilical artery, and therefore gave a false reading, which led to an excess of oxygen being administered. This resulted inter alia in near-blindness (retrolental fibroplasia, or R.L.F.) in the plaintiff. The junior doctor had asked a more experienced senior registrar colleague to check the insertion; neither doctor realised that the monitoring catheter was wrongly placed, with the attendant consequences.

At trial, Pain J. held that the Health Authority had been negligent, that the causal link had been established and awarded damages in the sum of £116,199. On appeal by the Health Authority, two main isues were raised. The first was whether the doctors concerned had fallen below the appropriate standard of care. It was contended that the standard exigible from the actual doctors was merely that to be reasonably expected of any doctor possessing the same formal qualifications and practical experience. In other words, allowance should be made for any lack of

experience of a doctor, which might in turn suggest a broadening of consultants'legal responsibility.

The second major point raised by the appeal was whether the excess oxygen administered could be said to have caused the effective blindness. It was one of various "risk factors" for the condition which were present in relation to the plaintiff.[49] Lords Justice Mustill and Glidewell (Sir Nicolas Browne-Wilkinson V.-C. dissenting) held in essence in the Court of Appeal that inexperience was no defence to a case of medical negligence. A different, and perhaps more easily satisfied, test applying to junior doctors was therefore ruled out.[50] Several other possibilities were also canvassed, however. The most prominent of these is the suggestion by the dissenting Vice-Chancellor to the effect that the Health Authority might be directly liable in negligence for failure to provide staff of adequate skill. Some indirect variation of the standard applicable for the inexperienced might therefore be available, although it is doubtful how far this would afford a remedy as it is thought that establishing such a case under the present law would be difficult. However, Lord Justice Mustill was of the view that inexperience would not justify a lowering of the

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[49]This point is an issue relating to causation and as such is dealt with elsewhere.

[50]See references to the N.C.E.P.O.D. Reports, supra and infra.

standard of care. That was to be defined in relation to the post actually held,[51] rather than the experience and characteristics of the individual doctor employed within that post. This approach is therefore objective rather than subjective. Furthermore, the test applied in Wilsher yielded as a result a post not merely as "houseman" but as doctor filling such a post in a specialist premature baby-care unit. The standard thus was tailored as closely as possible to the post in which the allegedly negligent doctor found himself.

Mustill L.J. considered three basic possibilities regarding the standard of care.[52] Before doing so, he stated that the issue of direct liability by the health authority had not been used as a basis for the plaintiff's argument. The point at issue was therefore the liability of doctors for whom the health authority was vicariously responsible.

The first possibility considered was the so-called "team" standard of care. As its name implies, it would involve "each of the persons who formed the staff of the unit [holding] themselves out as capable of undertaking the specialised procedures which that unit set out to

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[51]The actual post held by a doctor is likely to be determined partly by what post is available, in which area and specialty. It must thus contain an element of chance - hardly a suitable criterion to incorporate in the computation of the standard of care, but a consequence of this approach.

[52]Opinion of Mustill L.J., in Wilsher, cit. sup., pp. 811-815.

perform".[53] This view was rejected by his Lordship. It would entail that a student nurse be judged on the same standard as a consultant surgeon on the overall result of the team's performance. His Lordship also appeared to consider that the imposition of a uniform standard for the unit would in effect[54] lead back to direct liability by the health authority, a line of argument disclaimed by counsel for the plaintiff.

A different approach was put forward by the defendants. The standard sought by them would adjudge the doctor on the basis of his actual qualifications and experience. This, too, was rejected. The first stated reason was that the standard of care received by the patient would as a result become a lottery, depending upon whether a novice or experienced doctor had treated him. This is open to doubt initially on the grounds that its underlying assumption that it is better to be treated by an experienced doctor is not perhaps automatically true. However, the second stated reason was that there was no justification for making junior doctors a special case when that did not happen in other comparable professions, in which "learning by doing" was unavoidable. It must be commented that, at least in the case of solicitors, it is possible for the trainee to learn in this way, whilst the

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[53]Opinion of Lord Justice Mustill, Wilsher, cit. sup., p. 812.

[54]Although by means which are unclear from his opinion.

principal, i.e. partner, expressly takes responsibility for the transaction and that the two are not necessarily incompatible, as this implies. The third formulation of the standard considered, that according to "post", was canvassed by his Lordship. This apparently meant the task or specialty which the doctor held himself out as performing, and not the "rank" of the individual filling that post. This standard, in Lord Justice Mustill's view, was not that of the "..averagely competent and well-informed junior houseman..",[55] but of the doctor "..who fills a post in a unit offering a highly specialised service".[56] Within this inheres the necessary flexibility to distinguish between consultant surgeons and nurses, for example, working in the same unit. Nevertheless, it is clear that the test also takes into account the holding out of that doctor as a member of a specialist unit and therefore providing specialist care.

Glidewell L. J. also considered the appropriate standard of care, generally agreeing with Mustill L.J. He, too, considered that no allowance should be made for

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[55]Mustill L.J., Wilsher, supra, p. 813h.

[56]Mustill L.J., ibid.; see Jones, Medical Negligence, supra, at pp. 85-90.

inexperience of the practitioner concerned. But he admits that this test is harsh. He suggests that the junior's duty will be complied with if he consults his superior (in fact the houseman in Wilsher consulted the unit's senior registrar and was ultimately held not to be negligent). It has been argued by Mason and McCall Smith[57] that a junior doctor may well be insufficiently experienced so as not to know when matters are at risk of going wrong and thus when a superior should be called in. But, unless that doctor consults his superiors in each case, he is effectively thrown back upon a standard of care based upon the qualified doctor.[58] They also comment that negligent delegation of responsibility by a consultant to a junior doctor could amount to direct negligence on the part of the former.[59]

Glidewell L.J. also rejected the "team" standard of care, and held the junior doctor not negligent in calling in the senior registrar, but did hold the latter negligent for his failure to notice and remedy the mistake of his junior colleague. Interestingly, his Lordship also commented that[60] he saw no reason why the health authority

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[57]Law and Medical Ethics, J. K. Mason and R. A. A. McCall Smith, third edition, 1991, Butterworths, at p. 216.

[58]Ibid.

[59]Ibid.

[60]Opinion of Glidewell L.J., Wilsher, cit. sup., at p. 831d-g.

should not be adjudged negligent in appropriate cases for a failure to provide adequately skilled staff in sufficient number.[61]

Inexperience and the Duty of Care

The Vice-Chancellor in Wilsher differed from his brethren.[62] Whereas in the normal case a doctor was under a duty to pass to another doctor a patient whose treatment was beyond his capacity, that did not apply to the training of housemen in treating patients. A subjective view was therefore required by the Vice-Chancellor's test: "[I]n my judgement, such doctors cannot in fairness be said to be at fault if, at the start of their time, they lack the very skills which they are seeking to acquire".[63]

In saying this, his Lordship clearly adverts to the underlying factual situation, and is to be commended for a common-sense approach. It was precisely this feature of the case which led Lord Justice Glidewell to mitigate his test with the suggestion that the junior doctor might discharge his burden by seeking the assistance of his

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[61]This is approaching perilously close to the public law based actions on allocation of resources. Clearly such a case would require to be framed with the utmost care in order to succeed on the basis of negligence.

[62]Opinion of Sir Nicolas Browne-Wilkinson, V.-C., Wilsher, cit. sup., at p. 832 et seq.

[63]Opinion of Sir Nicolas Browne-Wilkinson, V.-C., Wilsher, cit. sup., at p. 833d.

senior colleagues. The test set out by the Vice-Chancellor was one in which liability would follow acts or omissions which a "careful doctor with his qualifications and experience"[64] would not have allowed or committed respectively.[65] He added that a health authority should not be liable vicariously for negligence solely attributable to inexperience. One difficulty which he anticipated is that his proposed test would depend upon the seniority of the doctor who treated the patient - very possibly a matter of chance. He comments that this is not the law,[66] and proposes a solution along the lines of direct liability. If the health authority has failed to provide a doctor of sufficient skill and experience to undertake the clinical work, and that doctor has been negligent, then the authority may be directly liable. Although his Lordship describes this as direct liability, it also bears similarities to an extended doctrine of vicarious liability inasmuch as it visits liability upon another party to the one who has de facto been negligent. Despite these and other problems, however, his Lordship considers that its benefits outweigh its disadvantages, principally that of making unwarranted findings of negligence against junior

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[64]Opinion of Sir Nicolas Browne-Wilkinson, V.-C., Wilsher, cit. sup., p. 833f.

[65]Opinion of Sir Nicolas Browne-Wilkinson, V.-C., Wilsher, cit. sup., p. 833f.

[66]Opinion of Sir Nicolas Browne-Wilkinson, V.-C., Wilsher, cit. sup., p. 833g.

doctors. Although his approach to the test differed from that of his brethren, he agreed that the junior doctor had discharged the standard of care upon him, but that his senior registrar colleague had not. In summary, the "team" standard of care and a defence of inexperience were both rejected by majority, and only the more senior doctor was unanimously found negligent.[67]

Whilst in cases of medical negligence the Scottish courts have continued to apply traditional rules more strictly, this has accompanied a strong retrenchment on the wider horizon of the law of tort and delict.[68] It is thought that Wilsher, as a recent and authoritative English case, consistent with the strict approach in Kay v. Ayrshire and Arran Health Board,[69] is likely to be followed in appropriate Scottish cases. There is little authority of a similar nature in Scots law. In Junor v. McNicol[70], a house officer was held not to be negligent in failing to

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[67]The appeal in this case to the House of Lords was on the ground of causation; the House agreed with the Vice-Chancellor that causation was not established on the balance of probabilities. See Lord Bridge's opinion, [1988] 1 All E. R. 871 at p. 874g.

[68]See inter alia Junior Books v. The Veitchi Co. Ltd, Tai Hing Cotton Mill Ltd. v. Liu Chong Hing Bank Ltd. and Others and Murphy v. Brentwood District Council, all cited supra: see also, The Future of Liability for Defective Buildings, H.L. MacQueen, 1990 S.L.T. 337.

[69]1987 S.L.T. 577

[70]"Times", 26 March 1959; see Medical Negligence: An Introduction, J. A. Cameron, Q.C., Law Society of Scotland, 1983 for an account of the case.

administer penicillin injections: the junior doctor was following the instructions of the consultant responsible for the case.[71] This case gives some support to the argument that the consultant in charge should himself be held legally responsible for the actions of his junior colleagues, by a variation of the existing principle of vicarious liability.

Novices have been considered elsewhere in the law of delict and tort. In Nettleship v. Weston,[72] a learner driver was held to have satisfied the standard applicable to those drivers of reasonable or ordinary skill. Thus no allowance was made for inexperience, nor, as is strongly argued in this thesis,[73] for ascription of legal responsibility to those doctors charged with day-to-day responsibility for patient-care and clinical training. Jones v. Manchester Corporation[74] involved a hospital board and a doctor being sued jointly for negligence. The majority (Lord Denning and Lord Singleton) did not envisage any allowance for the relative inexperience of a co-

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[71]As has been noted already, this responsibility will only rarely co-exist with legal responsibility in the typical N.H.S. hospital medicine case.

[72][1971] 2 Q.B. 691

[73]And is incorporated as part of the writer's proposals for reform in the last two chapters of this thesis.

[74][1952] 2 Q.B. 852

defendant upon whose actions the case was partly based.[75] There is, however, some authority for a raising of the standard of care where an individual's professional experience and qualifications make this appropriate: Wimpey Construction (U.K.) Ltd v. Poole.[76] This is at variance with the approach set out by the Court of Appeal in Wilsher.[77] It is argued by them that application of the Wimpey principle would result only in a raising of the standard of care where the experience of the individual professional merited it, rather than a reduction. The case, however, was not considered by the Court of Appeal in Wilsher and dealt with the ambit of an insurance clause, in

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[75]The rest of the case is taken up with a consideration of an indemnity between the defendant and the hospital authority, the effect of which is superseded. However, the board was ultimately found liable to the extent of eighty per centum for damages, in respect that there was inadequate provision of adequately skilled medical staff. In the light of the different, statutory framework under which the National Health Service functions, doubts must be expressed over the weight as authority of this case in that context.

[76][1984] 2 Lloyd's Reports 499

[77]Wilsher, cit. sup.; see Mason and McCall Smith, cit. sup., at p. 205.

a contractual context.[78] However, in Wimpey, Webster J. considered the test for negligence in the context of the activities of the insured's design department, and said,

> "..where a professional man has knowledge, and acts or fails to act in a way which, having that knowledge he ought reasonably to foresee would cause damage, then, if other aspects of duty are present, he would be liable in negligence by virtue of the direct application of Lord Atkin's test in [Donoghue v. Stevenson]".[79]

Clearly, Webster J. thought the application of the Bolam and Donoghue tests sufficient in terms to judge the "expert" by his fellow expert.

Variation of the Duty of Care

The Australian case of Cook v. Cook,[80] an appeal to the High Court of Australia, is an interesting development of the concept of the duty of care, and its modification in the light of the relationship of the parties. This indicates

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[78]Although the test for professional negligence set out in Bolam was considered. It was thought not to rule out a test incorporating a subjective element of the individual doctor's qualifications and abilities. However, an issue canvassed but not decided in Duchess of Argyll v. Beuselinck [1972] 2 Lloyd's Reports 172, discussed by Webster J. in Wimpey, was whether someone with a higher than normal degree of skill retained contractually would be subject to a different (i.e. higher) standard of care as a result. This question is clearly influenced by the element of delectus personae involved in selecting someone under a contract. The case did not envisage any allowance being made for the inexperience of a junior solicitor.

[79]Opinion of Webster J. in Wimpey, cit. sup., at p. 506 et seq. Donoghue v. Stevenson, Opinion of Lord Atkin, [1932] A.C. 562, at p! 580.

[80][1986] 162 C.L.R. 376

the potential flexibility of the common law to adapt the standard of care, even within the exisitng law, to the circumstances of the case. In the light of the findings of the first and second N.C.E.P.O.D. Reports[81], this strengthens the argument that the de facto responsibility of consultant doctors in particular should be reflected in the law to a greater extent than is the case.

Cook also concerned the position of the novice and did not follow the English case of Nettleship v. Weston,[82] which was authority to the effect that no adjustment to the standard of care was indicated in a case where the tortfeasor was a novice. In Cook, an unlicensed and inexperienced driver was invited - and indeed encouraged - to drive a car for practice, the person giving the encouragement being the passenger and subsequently the plaintiff. In attempting unsuccessfully to avoid hitting a parked car, the driver lost control of the car and crashed, thus occasioning injury to the passenger. The issue for the court was put briefly by the majority, and was

> "..whether the duty of care owed by such a driver to a passenger under the common law of negligence invariably requires that the driver exercise the degree of skill which could reasonably be expected of an experienced and competent driver in the circumstances notwithstanding that a basic ingredient of the relationship between the particular driver and the particular passenger

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[81]Discussed supra and infra.

[82][1971] 2 Q.B. 691

> is their mutual knowledge that the driver is unqualified and lacks that skill".[83]

It may be mentioned initially that the point under consideration by the court was not that of volenti non fit injuria. This is, of course, because the plaintiff could not be said to have consented to the injuries which were received. Thus the court in this case concentrated upon the issue of inexperience in the context of the special knowledge of this level of experience by the plaintiff. Furthermore, actual knowledge and not merely imputed or constructive knowledge was involved. For the law of medical negligence, it may be seen that the Cook-type special knowledge of a doctor's experience and competence could only arise where the patient has the requisite knowledge - it is thought very rarely.

At trial, Lewis J. had found that the accident had been caused not by carelessness but by inexperience. Applying a test based upon the reasonable novice, the case was dismissed. On the initial appeal, the Supreme Court of South Australia was divided upon the issue of the standard of care.[84] King C.J. agreed with the trial judge regarding the standard of care. Matheson and Johnston JJ. agreed that the Nettleship v. Weston[85] standard, i.e. that of a

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[83]Cook v. Cook, cit. sup., per majority, at pp. 378-379. See also Weir v. Wyper 1992 S.L.T. 579 (O.H.).

[84][1986] 162 D.L.R. 376

[85]Cit. sup.

reasonably competent driver, should apply. However, King C.J. rejected a defence of volenti non fit injuria but found there to be contributory negligence, whereas the latter accepted the plea of volenti. On ultimate appeal to the High Court, it was considered that Johnston J. had applied a test in effect of the standard of the novice or inexperienced driver. He found the driver negligent on this standard. However, the High Court held that the issues of volenti and of contributory negligence did not preclude consideration of the effect of special knowledge and the relationship of the parties upon the standard of care.[86] Although the High Court accepted that the normal standard of care would not be affected, beyond being brought into existence by it, by any relationship of proximity between the driver and passenger, they considered that this relationship could not and indeed should not become standardized by the law after this threshold requirement had been met.[87] It was therefore possible that the content of the duty of care could be affected by important factors in that relationship. Further, the court thought that the facts of Cook were sufficiently special and exceptional as to transform this normal relationship between tortfeasor and victim and therefore to be capable of affecting the content of the applicable standard of

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[86]Cook v. Cook, cit. sup., at p. 381.

[87]Cook v. Cook, cit. sup., at p. 382 et seq.

care.[88] The questions of proximity and of the standard of care were therefore linked. The "reasonable man" test, whilst remaining essentially an objective one, would be confined to the compartment of the individual tortfeasor and victim, as dictated by the exigencies of the specific relationship of proximity. Some authority, inter alia Nettleship v. Weston[89], was adduced in support of this.

Whether this reasoning could successfully be applied to the case of medical negligence is unclear. It is thought that, apart from the holding out of a medical practitioner as such and relative lack of knowledge on the part of most patients, by contrast driving skills, or their lack, are much more readily perceived than the rather more abstract and arcane skills of the medical practitioner. The man in the Clapham omnibus may well feel confident of his ability to assess drivers even if he does not himself hold a driving licence, but he is less likely to be able to do the equivalent in medical practice. He may not even be able to detect that anything has gone wrong - particularly if he is under anaesthetic at the time. It might also be argued that in any event, the doctrines of volenti and of contributory negligence are adequate to deal with cases in which there is some knowledge of and assent to the ultimate

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[88] Cook v. Cook, opinion of the majority, cit. sup., at p. 383.

[89] Cit. sup.

harm.[90] The majority in Cook stressed two aspects of the case. The first was the special, exceptional circumstances of the case, and the second was the specific aspect that the driver's lack of ability was known and accepted by the passenger. Further, a distinction was sought to be drawn between errors caused by inexperience per se, and by superimposed carelessness.[91] They identified on one hand the possibility that an inexperienced driver could make a mistake consonant with his lack of experience but without negligence[92] and on the other that an inexperienced driver could be negligent in the exercise of his lower standard of ability. The duty of care should be modified in the light of proximity and of exceptional circumstances, both of which the court thought were present. However, it held that the driver had in fact been careless additionally to the standard to be expected in deliberately accelerating in order to avoid hitting the vehicle in her path, thereby causing the actual although different accident. The acceleration was a cause of the accident and greatly

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[90]It must of course be borne in mind that these two doctrines say nothing about modifying the standard of care or the existence of the duty. Thus the Cook approach is novel inasmuch as it is qualitatively different from these apparently similar doctrines.

[91]Cook v. Cook, cit. sup., opinion of the majority, at p. 389.

[92]Although it might reasonably be supposed that his lack of experience might render such a mistake and probable resulting accident more serious than its equivalent in a qualified and experienced driver.

increased its severity. There had been a breach of the lower standard of care. The High Court agreed with the majority in the court below to the extent that negligence was present, but on the test to be applied, it agreed with the dissenting King C.J. It was observed[93] that the question of volenti could not be considered because it could not exonerate the driver from a "..failure to observe the standard of care which might reasonably be expected of an unqualified and inexperienced driver".[94] However, it may be commented that the operation of the doctrine of volenti is to absolve the defender[95] of the "consequences arising from that negligence"[96] rather than to affect the duty itself. Volenti[97] and indeed contributory negligence are rarely if ever considered in the reported cases, even those concerning liability for suicide attempts whilst the victim is in hospital. The question of varying the standard of care is therefore unlikely to arise in the context of the relationship of proximity of the parties, or of special

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[93]Cook v. Cook, cit. sup., at p. 389.

[94]Cook v. Cook, cit. sup., at p. 389.

[95]Or defendant, depending upon jurisdiction.

[96]Per Lord Justice-Clerk Wheatley in Winnik v. Dick, 1984 S.L.T. 185 at p. 188.

[97]Although there is nothing in principle to prevent this doctrine being employed, the patient's lack of knowledge of medicine - or possible unconsciousness at the relevant time if anaesthetised - probably militates against it in practice.

knowledge or acceptance of a lower standard of care.[98] However, a varied standard of care has been considered in relation to the level of experience and knowledge of the doctor.[99] It was, however, rejected in favour of a uniform standard based upon the doctor holding that post in the specialist unit, with no allowance being made for inexperience.[100] It is the application of the test to specialist medical units which, it is thought, causes the greatest complexity. There is some authority showing that the Scottish courts have considered an aspect of this, where the existence of a duty of care has been negatived by a common criminal purpose.[101] Even where a common criminal purpose has been established, it appears that a duty of care will not necessarily be wholly negated. Although Wilson v. Price[102] and Winnik v. Dick[103] did not require to consider this, Weir v. Wyper[104] demonstrates that the facts and circumstances of the case should be assessed. In Weir,

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[98]Although arguably this might be of application where a patient knows that he or she is being treated by a junior or training-grade doctor. This might carry the disadvantage recognised by the Court of Appeal in Wilsher that a two- or multi-tier system of healthcare might result from this in the longer term.

[99]Wilsher v. Essex Area Health Authority, cit. sup.

[100]See infra.

[101]Lindsay v. Poole 1984 S.L.T. 269.

[102]1989 S.L.T. 484

[103]1984 S.L.T. 185

[104]1992 S.L.T. 579 (O.H.)

a proof before answer was allowed on the question as to whether a criminal course of conduct had been engaged in. The pursuer, who had been aged sixteen at the time of the car accident, had asked a driver holding a provisional driving licence to drive her home unsupervised by a qualified driver. Lord Coulsfield doubted whether, in these circumstances, the pursuer's actions amounted to participation in a common criminal activity. It is submitted that such an approach is but a short step from that in Cook, and in turn from tempering the duty of care to the actor rather than the act elected to be performed.[105] At the time of writing, however, there is no indication that this more flexible approach is likely to be incorporated into the law of medical negligence. Inasmuch as there is such a substantial difference in knowledge between doctor and patient, the writer argues that a variable standard of care has rightly been rejected by the courts in the context of medical negligence claims. The rejection of this is consistent with the emphasis placed by the present writer upon an absolute standard of practice.

In conclusion, the standard of care in medical negligence claims, as one of the main junctions between the medical and legal facets of a claim, is an important part of this area of the law. It is submitted that the balance of the law in the standard of care (and causation) is

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[105]Especially in the light of a comparable English decision in Pitts v. Hunt (1990) 3 W.L.R. 542.

presently weighted in favour of the doctor, and that this is likely to continue in the ambience of the recent "backlash" identified in the law of tort[106] (and delict[107]). This chapter has also sought to criticise the test employed to determine that standard: its strong emphasis upon common practice, despite the courts' power to hold such to be negligent, the reliance upon and limitations of vicarious, and consultants', liability and the weight necessarily given to expert testimony although this is unavoidable. These serious criticisms, it is submitted, in turn raise the deeper question of the justification for the embodiment of the fault principle in this test, and it is this issue to which the thesis now turns.

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[106]Raising the Standard of Care, J. Holyoak, 1990 Legal Studies 201 at p. 201.

[107]See, inter alia, Rethinking Negligence, J.G. Logie, 1988 S.L.T. 185.

Chapter IV

The Moral Basis of Fault

Introduction

In this section, a brief consideration of aspects of the fault principle in the law of delict and tort, and the nature of its relationship to morality, will be offered. The aim is to explore the existence and application of any moral basis of fault in the law of medical negligence.[1] In order to achieve this, three intertwined discussions will be undertaken. The first is represented by legal writers.[2] Thereafter, recent discussions of the moral basis of fault, principally by American commentators, will be considered,[3] incorporating where appropriate (and thirdly) reference to the general formulae for assessing fault in the law of medical negligence. The approach is therefore both theoretical and practical. The writer seeks to argue that the notion of moral fault is not sufficiently reflected in the law of medical negligence as to explain or justify it

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[1]In doing so it is of course necessary to consider some arguments framed generally for tort and delict. Full consideration of this debate is inappropriate, however, for the more specialised aims of the present work.

[2]No attempt will be made to resolve such issues as the provenance of culpa in Scots law; such aims are outwith the scope of the present work.

[3]Fault liability in this debate will principally be considered, although in the literature much attention is also devoted to strict liability. The former is more relevant for this work, given the present basis for actions of medical negligence. Dictates of space prevent full consideration of the topic of strict liability.

consistently and satisfactorily,[4] nor that principles of corrective justice are satisfactorily reflected in the law. In turn, this means that to the extent desirable those characteristics or qualities claimed for "the fault principle" which are to be valued may be as well, or better, attained by alternative means.[5] Such means are discussed later in the appropriate context of reform.

Theoretical Approaches

Before consideration of the recent discussion on the fault principle, it is appropriate to begin by attempting to elucidate what is meant by the term.

In common usage, the word "fault" seems inseparable from some connotation of imperfection, if not moral blameworthiness as well. It has been defined recently as

> "an imperfection or defect,...,a mistake or error,...,something wrongly done; offence,...,the responsibility for wrongdoing or failure" and derived

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[4]Readers are referred to the six heads in the "indictment of the fault principle" in Atiyah's Accidents, Compensation and the Law, by Peter Cane, fourth edition, Weidenfeld and Nicolson, 1987, in ch. 19.

[5]Indeed, some moral content in the law is probably both vital and desirable, and the present writer would not gainsay this. A much more limited aim is that espoused in the present chapter. It will emerge that it does not not necessarily follow that the only, or best, way to achieve some such moral content is by the fault-based negligence system. This idea has recently been put forward strongly by more than one scholar in this field.

ultimately from the old French word, "faute".[6] This has been the case for a considerable period of time.[7] Although a definition wholly avoiding tautology may be impossible, the theme appears, unsurprisingly, to be rooted in ideas of right and wrong. Let us first consider the approach to morality in delict or tort in general, in relation to the law of negligence.

Stair, under the title heading of "reparation"[8], refers to obligations which arise by "delinquence". Such obligations arise "without any convention, consent, or contract, either particularly, or only by virtue of any positive law; and therefore, they must needs have their original from the authority and will of God, and of our obedience thereto".[9] Although Stair's categories of obediential obligations are not necessarily congruent with what is presently meant by fault, the underpinning of his view is that a dereliction or failure to perform these

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[6]Wordmaster Dictionary, Penguin, M.H. Manser and N. D. Turton, Penguin, 1987, at p. 255.

[7]For example, in 1944 the Shorter Oxford English Dictionary listed "failing", "defect", "imperfection" and "responsibility for an untoward occurrence": Shorter Oxford English Dictionary, Clarendon Press, Oxford, Third Edition (1944) at pp. 681-682; it is interesting to note that the revised version of 1955 also encompassed the same meanings, but including at one point a reference to "sin"!

[8]The Institutions of the Law of Scotland, Stair, 1693, ed. by D. M. Walker, The University Presses of Edinburgh and Glasgow, 1981, Book 1, Title 9, at pp. 168-169.

[9]Stair, op. cit., at Book I, title 9, at pp. 168-169.

duties has taken place.[10] This probably represents in part the consanguinity of the early criminal law and law of delict.

Walker states that,

> "[t]he second precept, enjoining forbearance from inflicting harm, has as its corollary that reparation should be made by one who does harm to his neighbour. The province of the law of delict, stated most generally, is therefore the legal duties of forbearance from inflicting harm on others and the consequential duty of making reparation if and when harm has been done."[11]

Whereas this does little to emphasize either fault or morality, the author continues by quoting from Erskine:[12]

> " "(a)lterum non laedere is one of the three general precepts laid down by Justinian,[13] which it has been the chief purpose of all civil enacments (sic) to enforce. In consequence of this rule, every one who has the exercise of reason, and so can distinguish between right and wrong, is naturally obliged to make up the damage befalling his neighbour from a wrong committed by himself. Wherefore every fraudulent contrivance, or unwarrantable act, by which another suffers

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[10]See for example the eighteenth edition of Erskine (by Rankine, Bell and Bradfute, 1890). The author comments at Book III, title 1, para. 4: "[o]bligations, when considered with regard to their cause, were divided by the Romans into those arising from contract, quasi-contract, delict, and quasi-delict. But there are certain obligations, even full and proper ones, which cannot be derived from any of these sources, and to which Lord Stair gives the name of obediential. Such is, among others, the obligation of parents to aliment or maintain their children...".

[11]Delict, D. M. Walker, second edition, W. Green and Son, 1981, at p. 3.

[12]An Institute of the Law of Scotland, by John Erskine, eighth edition, 1870, by Badenach Nicholson.

[13]Walker, op. cit., at p.3, cites Justinian's Institutes (Corpus Juris Civilis) Book I, title 1, para. 3 and Digest, Book I, title 1, para. 10.

> damage, or runs the hazard of it, subjects the delinquent to reparation." "[14]

By contrast, this gives an indication that some notion of moral fault underlies the legal concept of fault, although Walker primarily stresses the adjustment of losses rather than ascription of fault.[15] [16] The present writer seeks at this stage only to try to demonstrate that moral notions of fault are present in some of the Institutional writings, and not the discrete issue that any particular idea of morality or Roman legal concept underlies the modern law. It has been argued that,

> "[t]he material collected and analysed...does not support the proposition that the Scots law of reparation derived a principle or doctrine of culpa from Roman law in general or from the lex Aquilia in particular.....But the sporadic reliance on texts from the Digest or Institutes which use the term culpa does not prove that Scots law extracted from the Roman sources and applied a principle of culpa.....The more frequent occurrence in the cases of the word culpa itself without a specific reference to the

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[14]Walker, op. cit., at p. 3, quoting from Erskine's Institutes (cit. sup.), Book III, title 1, para. 13.

[15]Walker, op. cit., at p. 5. However, the author does advert to the moral implications: "[m]oreover a moral flavour has been imparted by the language of the courts in inquiring whether the defender was in "fault", or did "wrong"." Walker, op. cit., at p. 5. This implies that the ascription of"moral" fault takes place after the analysis of legal fault, and that the former is not dependent upon the latter.

[16]Despite the fact that Walker, op. cit., at p. 42, quotes Lord Atkin in Donoghue v. Stevenson, 1932 S.C. (H.L.) 31 at p. 44 to the effect that a general sense of moral wrongdoing may underpin some of the law of delict, it is clear that both Lord Atkin and Walker consider that this cannot be the basis for all legal remedies in delict. Walker comments: (at p. 42) "What is fault? It is clearly not synonymous with moral fault..", and "[f]ault may be regarded as coextensive with absence of legal excuse or justification."

> Roman law shows merely that some advocates and judges preferred to reason with the help of a word derived from Roman law. It does not show that the rules or principles which they expressed in terms of culpa were derived from Roman law."[17]

Whether the modern Scots law of reparation has any connection with morality has been doubted, rather emphasizing the importance of the allocation of losses consequent upon harm. This is the view urged by Gow, who stresses "reasonableness" in his argument based upon the law of nuisance:[18]

> "The words "right" and "wrong", hallowed as they are by long usage, cannot now be got rid of, but their use should not obscure the fact that a law of reparation concerns itself with harms, and in particular unjustifiable harms. When, then, is a harm unjustifiable? The answer is when the actor has made unreasonable use of his rights or liberty."[19]

This has been strongly countered by Elliott, who has argued that a moral basis of fault exists in culpa, and that this is desirable.[20] [21] Although the present writer considers

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[17]Culpa in the Scots Law of Reparation, G. MacCormack, 1974 J.R. 13, at p. 26.

[18]Gow, Is Culpa Amoral?, 1953 J.R. 17.

[19]Gow, op. cit., at p. 35.

[20]See, What is Culpa?, 1954 J.R. 6. To the extent that this debate is predicated on the law of nuisance, and the case of Rylands v. Fletcher (1868) L.R. 3 H.L. 330, it is now superseded by the case of R.H.M. Bakeries v. Strathclyde Regional Council, 1985 S.L.T. 214. It appears that liability for nuisance in Scots law, as a result of R.H.M. Bakeries, is based on fault. This, to some degree, strengthens the argument advanced by Elliott, supra.

[21]The related debate on the terminology of the lex aquilia/actio injuriarum is outwith the scope of the present discussion. See, for example, Designation of Delictual Actions: Damn Injuria Damn, T. B. Smith, 1972 S.L.T. (News) 125, and Damn

that the modern law does reflect a move away from the so-called moral basis, it is not disputed that a finding of negligence may, though not necessarily, coincide with a moral defect.[22] [23]

At this point, it is interesting to consider the attitude to moral fault evinced by textbook writers on the modern English law.

Relatively little discussion is offered on fault and its relationship to morality. Street emphasizes the allocation of loss model of tort and the pervasive influence of insurance.[24] Salmond and Heuston refer to the original author's support of liability's being based upon fault,[25] and comment that "[f]ault has never been, and is not today, an essential element in tortious liability."[26] More illuminating is a subsequent comment on the

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Injuria Again, T. B. Smith, 1984 S.L.T. (News) 85.

[22]This is of course in the context of a negligent act, rather than an intentional civil wrong.

[23]To concentrate on this aspect of the debate is not, it is submitted, to deny that moral fault, or indeed a non-moral, legal conception of fault, has no part to play in the law. Particularly in the context of the law of medical negligence, the influence and utility of the moral and economic deterrence which some claim for the law of tort or delict, will be considered.

[24]Street, The Law of Torts, by Brazier, eighth edition, Butterworths, 1988 at p. 10.

[25]Salmond and Heuston on the Law of Torts, by Heuston and Buckley, nineteenth edition, Sweet and Maxwell, 1987, at p. 24, referring to the most recent edition written by Salmond (Salmond on the Law of Torts, sixth edition, 1924), at pp. 12-13.

[26]Salmond and Heuston, op. cit., at p. 25.

relationship of moral defect to legal fault:

> "[I]t is clear that to Salmond, with his emphasis on mens rea, fault was a matter of personal shortcoming. But the "fault" upon which liability may rest is social fault, which may, but does not necessarily, coincide with personal immorality. The law finds "fault" in a failure to live up to an ideal standard of conduct which may be beyond the knowledge or capacity of the individual."[27]

Whilst acknowledging that the legal principle of fault had an "affinity"[28] with the criminal law, Winfield and Jolowicz argue implicitly that morality has a loose connection with the legal "fault principle", in its deterrent effect and regulation of individual responsibility.[29] Nevertheless, their view appears to be that in practice this effect is difficult to quantify, and is of limited extent.[30]

In conclusion, it is submitted that these authorities demonstrate some serious reservations as to whether the legal principle of "fault" in the general law of tort or

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[27]Salmond and Heuston, op. cit., at p. 26. The authors of this work point out (at p. 27) that it followed from the original Salmond view that the award of damages was substantially punitive in nature. Although they comment (at p. 27) that such a view has never formed part of the substance of the law, some would argue that the related concept of deterrence, and regulation of individual responsibility, fulfil the formal requirements of morality, even if the content differs from Salmond's view. See, for example, Salmond and Heuston, op. cit. at p. 28, and New Zealand's Accident Compensation Scheme: A Tort Lawyer's Perspective, L. N. Klar, (1983) 22 Univ. Toronto L. J. 80 (discussed infra in the context of reform).

[28]Winfield and Jolowicz on Tort, by Rogers, thirteenth edition, Sweet and Maxwell, 1989, at p. 24.

[29]Winfield and Jolowicz, op. cit., at pp. 24-27.

[30]Winfield and Jolowicz, op. cit., discuss this at pp. 27-30.

delict bears a necessary or automatic relationship to actual moral fault. It has been said that,

> "[p]aradoxically, the fault concept itself, in origin contemplating only interpersonal justice, eventually opened itself to a consideration also of social needs, distributive justice and stricter liability. This transformation has been rapidly gaining pace since the individualistic fault dogma began to yield to the mid-20th century quest for social security, and the function of the law of torts came to be seen less in its admonitory value than in ensuring compensation of accident victims and distributing the cost among those who can best bear it."[31]

Where negligence, rather than other areas of the law of delict or tort, is concerned, the extent to which a perceived moral shortcoming may coincide with the legal test of fault is thought to be much greater.[32] This is because that area more closely resembles the earlier criterion of wrongdoing, rather than harm. An objection may be raised that unintentional conduct may be more difficult to stigmatise as a moral failure than an intentional civil wrong.[33] Before consideration of the American analyses, we may note that recent concerns in this area have been aptly summarised in the following terms:

> "...by far the greatest attention and criticism is focused (sic) upon compensation through the tort of negligence for personal injury. It is indeed beyond question that the operation of the law in this area is vulnerable to powerful criticism. While the various objections overlap,

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[31]The Law of Torts, J. G. Fleming, seventh edition, The Law Book Company Limited, 1987, at p. 94.

[32]Cf. The Advantages of Fault, W.W. McBryde, 1975 20 J.R. 32.

[33]Winfield and Jolowicz, op. cit., at p. 25.

> they can nevertheless be conveniently grouped under three main heads. The first is that tort is an extremely inefficient and wasteful system for compensating victims of personal injury. The second is that its operation, both in theory and in practice, is arbitrary and capricious. The third is that the spread of liability insurance, which shields tortfeasors in many situations from the financial consequences of their actions, has effectively deprived the tort of negligence of any moral basis which it might once have had."[34]

American Approaches

Inasmuch as American tort law seeks to resolve the similar potentially conflicting requirements, and indeed criticism, of the tort system, it is instructive to consider the essence of this debate. At the outset it must be emphasized that the discussion to which reference will be made encompasses the law of tort - and therefore by implication the law of delict - in its entirety. To attempt to conclude this substantial issue is outwith the scope of this work. The aim of this section is to discuss the main arguments and ultimately to assess their relevance to the law of medical negligence. However, it is pertinent to inquire as to the reason for considering these issues. In response, it is contended that one of the major tasks of this thesis is to analyse the theoretical and practical

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[34]The Modern Law of Negligence, R. A. Buckley, London, Butterworths, 1988, at p. 378. In fact, insurance must dilute the effect of a finding of fault. It is arguable that the fact that negligence is capable of being insured against means that it loses some of its moral culpability, if any; after all, it is not possible to insure oneself against committing crimes!

aspects of the fault principle in the law of medical negligence. Accordingly, although the literature discusses the law of tort[35] generally, a critique of the aims and objectives of the fault principle in general is likely to contain implications for our purpose. The risk that medical treatment, however expert its provider, might be unsuccessful is a factor which arguably differentiates all "professional" activities from the usual example of a case in negligence. There is a clear margin for non-negligent error in medical negligence cases, reflecting this intrinsic inability of the discipline to guarantee outcomes.[36] Thus,

> "[C]entral to decisions in cases of medical negligence is the undisputed fact that in all medical practice there is a risk. Even the most prudent or technically brilliant physician cannot guarantee absolute safety or success in the medical transaction. Thus, his liability has to be limited to those cases where the resultant harm was demonstrably due to his falling below the accepted level of care. This level, which is at the root of the negligence action, is set by the courts on the evidence of medical practitioners themselves."[37]

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[35]Again, by implication also the law of delict.

[36]"The true position is that an error of judgment may, or may not, be negligent; it depends on the nature of the error. If it is one which would not have been made by a reasonably competent professional man professing to have the standard and type of skill that the defendant held himself out as having, and acting with ordinary care, then it is negligent." Whitehouse v. Jordan [1981] 1 W.L.R. 246, per Lord Fraser at p. 263.

[37]Medicine, Morals and the Law, S. McLean and G. Maher, Gower, 1983, chapter eight (Negligence), at p. 156.

Two principal stages may be discerned in the literature.[38] The aims and objectives of the law are discussed, and then the extent to which these are realised. One of the sources of energy which underlies this debate was the American economic analysis of law, the principal exponent of which is Calabresi.[39] The essence of his theory is that both the cost of accidents and accident avoidance should be minimised so far as consonant with fairness; the unmodified fault principle is argued not to achieve this. It must, however, be observed that a substantial apparent reason for the gestation of such theories was the increase in motor vehicle accidents in the United States in the late 1960s.[40] Hence, it must be borne in mind that economic analyses based on this must be viewed with caution. The reasons for this are twofold. Firstly, it may be that motor vehicle claims are frequent and so readily detectable, the insurance of associated risks and processing of claims so efficient and streamlined, that this model provides a peculiarly apt vehicle[41] for economic analysis. Secondly,

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[38]Both as regards the law of tort (delict) and the law of negligence. At present, we shall concentrate on the "fault principle"; causation and other issues will be dealt with separately (infra).

[39]The Costs of Accidents: A Legal and Economic Analysis, G. Calabresi, Yale University Press, 1970.

[40]Calabresi, op. cit., at p. 3.

[41]The converse is that a discipline which is not readily visible or understandable to the ordinary man in the street, such as the practice of medicine, may therefore be a peculiarly inapt vehicle for economic analysis.

the underlying law of tort may be sufficiently differentiated from that obtaining in particular in Scotland and to medical negligence as to imperil reasoning by analogy between the two.

As regards the fault principle, though, Calabresi's primary aim is not to consider its merits or otherwise per se - rather it is to examine whether or not the principle meets the economic criteria of efficiency which he has previously set out. It is not therefore unreasonable to argue that his analysis is less concerned with the substantive content of the rules and more with their general reconciliation with his theory.[42] This suggests in turn the most fundamental criticism which may be made of such analyses. It is, of course, that the elusive influence of the concept of justice can neither be accounted for entirely in economic terms, nor can the substantive requirements of justice (or "fairness") be predicted in these terms. It is also argued that, once an unquantifiable element of "fairness" is introduced into the judicial equation, this renders similarly unquantifiable the extent and influence of the economic analysis. So argues Epstein, who advocates a "common-sense" approach:

> "A knowledge of the economic consequences of alternative legal arrangements can be of great importance, but even among those who analyse tort in economic terms there is acknowledgment of certain questions of "justice" or "fairness" rooted in common sense beliefs that cannot be explicated in terms of economic theory. Even if

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[42]See Calabresi, op. cit., at pp. 239-243.

> they cannot provide satisfactory answers to fairness questions, the advocates of economic analysis in the law still insist that their work is of primary importance because it reduces the area in which fairness arguments must be judged in order to reach a decision in a particular case. But once it is admitted that there are questions of fairness as between the parties that are not answerable in economic terms, the exact role of economic argument in the solution of legal question becomes impossible to determine."[43]

This criticism may also be made of other important economic theories, such as those of Posner[44] and to some extent the counter-movement, exemplified by Epstein's argument in favour of causally-determined strict liability.[45] Whereas these consider the moral basis of fault (and causation questions) incidentally to tort law in general, other writers have specifically dealt with the several models

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[43]A Theory of Strict Liability, R. Epstein, 1973 2 (University of Chicago) Journal of Legal Studies 151 at pp. 151-152. [In this quote, Epstein refers to an article by G. Calabresi and A. Douglas Melamed: Property Rules, Liability Rules, and Inalienability: One View of the Cathedral, 1972 85 Harv. Law Rev. 1089 at pp. 1102-1105, and also to R. A. Posner, A Theory of Negligence, 1972 1 Journal of Legal Studies 29. There is, however, nothing to suggest that Epstein's criticisms of economic analyses are not applicable to the latter in general.]

[44]Economic Analysis of Law, R. A. Posner, second edition, 1977; Little, Brown and Company (Boston and Toronto)

[45]A Theory of Strict Liability, R. A. Epstein, 1973 2 (University of Chicago) Journal of Legal Studies 151. See also Epstein's Theory of Strict Tort Liability, N.E. Simmonds, 1992 Cambridge L. J. 113 and The Structure of Tort Law, J.L. Coleman, 1988 97 Yale L. J. 1234.

underlying fault in negligence. The work of Coleman is an important example of this.[46]

From the foregoing, a suitable starting point for discussing the basis of the fault principle[47] is Epstein's comment that "(t)he task is to develop a normative theory of torts that takes into account common sense notions of individual responsibility".[48] One of the major reasons advanced for the fault principle is its regulation of individual responsibility. Others are the goals of elementary justice (presumably a large component of which is individual responsibility), deterrence, educating the public as to reasonable and unreasonable conduct, appeasing victims and allowing confrontation.[49] Let us examine the propositions which underly this.

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[46]Moral Theories of Torts: Their Scope and Limits: Part I, Jules L. Coleman, 1982 1 Law and Philosophy 371, and Moral Theories of Torts: Their Scope and Limits: Part II, Jules L. Coleman, 1983 2 Law and Philosophy 5.

[47]As we have seen, there seems to be no necessary or automatic congruence between this principle and moral notions, to the extent that this is discernible from the textbooks.

[48]A Theory of Strict Liability, Epstein, cit. sup., at p. 151. The present writer makes no comment on the substantive merits of this statement. Rather, the quote is intended to show a common reason advanced in support of the fault principle.

[49]These points are made in the course of a discussion of New Zealand's Accident Compensation Scheme, and the Woodhouse Report (which led to its being established), in an article by L. N. Klar, New Zealand's Accident Compensation Scheme: A Tort Lawyer's Perspective, 1983 33 Univ. Toronto Law J. 80 at pp. 92-93.

Underlying Assumptions

The first point which arises is why we are considering "fault", either legally or morally, at all?[50]

Each individual human being has no choice about his or her coming into existence. As life progresses, it is evident that most humans experience hardship and happiness in reasonable proportion, although it has been said that "[B]ut in this world nothing can be said to be certain, except death and taxes".[51] These trite observations are made as a reminder that the individual's fortunes wax and wane, until they cease to sound in creation. Therefore, by our very existence, we must be deemed to accept that bad fortune is in some degree inseparable from life. One of various possible expressions of this argument is, of course, the death of the individual. If society cannot, or

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[50]This is of course a wide debate in its own right. In recent years, concern over the "tort remedy" per se has broadened to include compensation in general. See generally, Compensation and Support for Illness and Injury, D. Harris et al., Oxford Socio-Legal Studies, Clarendon Press, 1984, ch. 1; Atiyah's Accidents, Compensation and the Law, by Peter Cane, fourth edition, 1987, Weidenfeld and Nicolson, Part 1; Disease and the Compensation Debate, Jane Stapleton, Clarendon Press, Oxford, 1986 (discussed infra; cf. Principle and Pragmatism in the Compensation Debate, K. S. Abraham, 1987 7 Oxford J. Legal Studies 302).

[51]Written by Benjamin Franklin (Letter to Jean Baptiste Le Roy, 13 November 1789, writings, vol. X): reference and quotation from The Concise Oxford Dictionary of Quotations, published by The Reprint Society (by arrangement with Oxford University Press), 1966, at p. 88.

will not, seek to attenuate hardship of every kind, it follows that neither will legal provision for doing so exist. There may be many different reasons for this. Amongst these, even those who advocate the wider attenuation of hardship, as an incarnation of an ideal, perhaps, must concede that the resource implications of so doing constitute an obstacle to its realisation.[52] Alternatively, others would argue that the individual must accept responsibility for him- or her-self, and for a large degree of the risks inherent in existence.[53] It is between these two extremes that society, and the law, attempt to achieve a balance.

However, any civilized society, to a varying extent, prides itself upon its care for the less fortunate members of that society. This may be manifested in many different ways. One example of it may be the development of the legal system itself, as a means of regulating disputes and ordering society. The difficulty which faces such a society is enormous. Whereas some categories of the less fortunate are readily identifiable on a society-wide

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[52]It may be observed that in many cases the law provides only a minimum standard of conduct with which the individual must comply, rather than providing a higher, or ideal, standard upon which aspirations could be placed. No doubt to do so would be impracticable!

[53]To the extent that these contain political implications, it must be stressed that the present writer does not seek to support, or argue from, any political affiliation whatsoever.

scale,[54] the provision which should be made for such groups, and whether others should be "re-advantaged", are matters likely to provoke serious disagreement. In addition, the unspoken assumption underlying these priorities is that there will be insufficient resources available to compensate everyone with some claim to alleviation of hardship. Such compensation need not be direct and financial; it may be rehabilitation,[55] direct care, re-training or a variety of other possibilities.[56]

It is this unspoken assumption which fuels the debate over the alleviation of hardship. Were the latter the only goal, and resources unlimited, no disagreement would arise. Thus the first complicating factor which we may identify is this scarcity of resources in the face of competing claims. The second complicating factor is, of course, the other

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[54]Excluding provision made informally by families, individuals and support groups.

[55]See, for example, Rehabilitation of Personal Injury Claimants, P. Cornes, 1989 S.L.T.(News) 129.

[56]Clearly, the hardship involved may involve the loss of something or someone, or something else irreplaceable. In this case, monetary compensation is given. Whereas the starting point for such compensation is arbitrary, it is possible after this has been fixed, to introduce an element of "comparative" logic into the award precedents. See, for example, Damages for Personal Injuries and Death, J. Munkman, eighth edition, Butterworths, 1989, at pp. 1-2: "Damages are simply a sum of money given as compensation for loss or harm of any kind"....."..it must be recognised that the primary rule is compensation. The rule that compensation is measured by the cost of repair, or restoring the original position - restitutio in integrum - is a derivative or secondary rule, which applies only if and so far as the original position can be restored. If it cannot, the law must endeavour to give a fair equivalent in money, so far as money can be an equivalent, and in that way "make good" the damage."

functions of the law in addition to alleviating hardship. Here the law has concurrent aims: tort law especially, it is argued, fulfils more than one purpose.[57]

An alternative approach where an individual has suffered hardship, rather than simply determining whether society can afford to alleviate it by any means, is to consider (in conjunction with the harm) its nature, and the circumstances in which it came into existence, i.e. a causally-based enquiry. This is what the Scottish and English legal systems have tended to do. In doing so, they have evolved criteria for choosing which forms of hardship, and the ways in which it may come into existence, should determine the question of recompense.[58]

With these conflicting requirements in mind, let us turn to the recent analysis of tort, principally by American writers, in considering the extent to which it is based upon moral factors. These analytical and philosophical discussions display a wide variety of different approaches. As Fletcher comments, "order and coherence" in tort is an ideal which is difficult to

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[57]See, New Zealand's Accident Compensation Scheme: A Tort Lawyer's Perspective, L. N. Klar, cit. sup.; Accidents, Costs and Legal Responsibility, S. Stoljar, 1973 36 M.L.R. 233; Disease and the Compensation Debate, Jane Stapleton, cit. sup.; Compensation and Support for Illness and Injury, D. Harris et al., cit. sup.

[58]Atiyah's Accidents, Compensation and the Law, by Peter Cane, op. cit., ch. 1.

attain;[59] it may well reflect the underlying nature of the subject under consideration.

Theorizing in tort or delict may take one or more of several different approaches. A theory may seek to analyse the existing law, i.e. be descriptive, or it may propound a normative approach, a version of what the law should be like, or principles by which the law may be measured and re-fashioned if necessary. Thus the general[60] and celebrated theory of Calabresi says that the law of tort should minimise costs both of accident compensation and of accident prevention consonant with fairness. In turn, he criticises the law of tort, and puts forward an alternative, based upon so-called "mixed" systems of fault and legislative controls for the efficient realisation of the economic analysis.[61]

The present writer agrees with the arguments put forward to the effect that the tort system is not wholly justified by reference to moral principles, and that this applies in turn to the law of medical negligence which for present purposes is a microcosm of the law of negligence

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[59]Synthesis in Tort Theory, George P. Fletcher, 1983 II Law and Philosophy at p. 64.

[60]I.e. not concerning the moral basis of tort as such.

[61]Calabresi, op. cit., Pt. VI (Towards a New System of Accident Law).

generally.[62] It is further suggested that Coleman's distinction between grounds of rectification and modes of rectification also applies to medical negligence. This means that the precepts of "justice" do not necessarily require the existence of the present remedy in tort or delict for the recompense of negligently-caused adverse effects. Fletcher comments that,

> "[F]or nearly two decades diverse schools of tort theory have attempted to reduce liability for personal injuries to a few basic principles. Calabresi advocates the principle of minimizing the total costs of accidents and accident avoidance; Posner advocates the principle of encouraging those activities whose benefits outweigh their costs. Epstein endorses a system of tort law in which causing harm is a sufficient condition of liability. My own [Fletcher's] work is read as advocacy of "non-reciprocal risk-taking" as a standard of liability".[63]

Relatively little argument in favour of a consistent and coherent moral basis for the law of tort is presented. The arguments in favour of this approach[64] have been systematically reviewed in the work of Coleman, to whom this thesis now turns.

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[62]This is because, as merely an area of professional activity to which the usual precepts apply, the same questions and issues are necessarily raised in connection with it.

[63]The Search for Synthesis in Tort Liability, George P. Fletcher, 1983 II Law and Philosophy at p. 63 (footnotes omitted).

[64]Towards a Moral Theory of Negligence Law, Ernest J. Weinrib, 1983 II Law and Philosophy 37; to a lesser degree in Tort Liability for Breach of Statute: A Natural Rights Perspective, J. Robert S. Prichard, Alan Brudner, 1983 II Law and Philosophy 89.

Coleman identifies the methods with which philosophy has sought to give tort law a moral basis, a process which he describes as one of providing a "rational reconstruction" of the law under one or other principles of justice.[65] His methodology is instructive in that it incorporates the various possibilities utilised in the effort to establish a moral basis of fault (and also strict liability, which need not concern us). Although other principles have been discerned,[66] those identified by Coleman are, it is submitted, the most important and will therefore be concentrated upon. They comprise:

(1) retributive justice;

(2) responsibility theory;

(3) reciprocity theory, and

(4) principles of corrective justice.[67]

These principles include the arguments of those, such as Weinrib,[68] who seek to argue that there is a moral basis for tort. The conclusion reached by Coleman, and with

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[65]Moral Theories of Torts: Their Scope and Limits: Part I, Jules L. Coleman, 1982 I Law and Philosophy 371 at p. 371.

[66]Those identified by Williams include appeasement, justice, deterrence and compensation. See The Aims of the Law of Tort, Glanville Williams, 1951 Current Legal Problems 137 at pp. 138-150.

[67]Coleman, op. cit., at pp. 371-372.

[68]Op. cit.

which the writer respectfully concurs, is that no one of these principles of justice can provide a basis for tort law, and although morality may be discernible in some propositions of the law "it cannot explain why we have adopted a tort system as the approach to vindicating these claims."[69] It will be noted that deterrence is not explicitly mentioned, as it is not considered a discrete "principle of justice" sufficient on its own to support unassisted the weight of the negligence and tort edifices.[70] It may nevertheless be a factor tending to support the existence of the tort and negligence system, and will be considered where appropriate in this context.[71] The writer is bolstered in this view by the excellent analysis of this subject put forward by Williams in 1951.[72]

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[69]Coleman, op. cit., Abstract, p. 371.

[70]It is nevertheless an important factor, and is considered in this thesis principally under the heading of reform.

[71]Somewhat similar remarks apply to compensation. See Theories of Compensation, Robert E. Goodin, 1989 9 Oxford J. Legal Studies 56.

[72]The Aims of the Law of Tort, Glanville Williams, 1951 Current Legal Problems 137, at p. 172: "[O]ur attempt to find a coherent purpose in the present law of tort cannot be said to have met with striking success....[W]here possible the law seems to like to ride two or three horses at once; but occasionally a situation occurs where one must be selected." (ibid., at p. 172).

Retributive Theory

Leaving aside his views upon strict liability,[73] we may consider firstly Coleman's view of retributive theories. Such theories are perhaps those with the most obvious claim to providing the moral basis in question. The statement of this theory set out in this article is circular: "..[F]ault in torts marks a moral defect in an actor for his conduct...[L]iability is justly imposed upon a faulty actor in order to penalize, punish or nullify his moral fault".[74] It will immediately be noticed that this is merely a statement of the aims of the theory, which when stated in this form does not provide justification for itself. Nor, as is pointed out, can it serve to justify strict liability, because "fault" is not then part of the legal calculus of liability.[75]

An important argument which is presented against a retributive basis of tort is the fundamental one that an individual may be found liable in tort in the absence of moral fault.[76] This, it is said, is because the standard of

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[73]Necessitated by considerations of space, and additionally because the focus of this thesis is medical negligence, i.e. restricted to fault-based liability for unintentional injury.

[74]Coleman, op. cit., at p. 374.

[75]Coleman, op. cit., at p. 374-375.

[76]Coleman, op. cit., at p. 375.

care is essentially objective rather than subjective: "[A]ccording to the objective test, a defendant is at fault whenever he fails to exercise the care of a reasonable man of ordinary prudence - whether or not the defendant himself is capable of compliance."[77]

It is submitted that in Scotland the standard of care in the law of negligence is significantly, and probably substantially, objective. It is that of the reasonable man, as laid down in the Scottish case of Muir v. Glasgow Corporation[78]. The opinion of Lord MacMillan in the case was that,

> "[L]egal liability is limited to those consequences of our acts which a reasonable man of ordinary intelligence and experience so acting would have in contemplation.....The standard of foresight of the reasonable man is, in one sense, an impersonal test. It eliminates the personal equation and is independent of the idiosyncracies of the particular person whose conduct is in question....The reasonable man is presumed to be free from both over-apprehension and from over-confidence, but there is a sense in which the standard of care of the reasonable man involves in its application a subjective element."[79]

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[77]Coleman, op. cit., at p. 375. (He cites, ibid., the case of Vaughan v. Menlove 3 Bing. N.C. 468 as authority for this objective standard.)

[78]1943 S.C.(H.L.) 3. It is interesting to speculate as to what proportion of the general population would constitute "reasonable men"; presumably, for example, convicted criminals would by definition require to be excluded from this category. How many of the rest would be suitable to be included, and by whose arbitration?

[79]1943 S.C.(H.L.) at p. 10.

The English law of tort adopts a similarly objective standard: for example, Buckley[80] cites Nettleship v. Weston[81] as an example of such a standard, and the inability of the learner driver to meet it, being incapable of so doing through inexperience, i.e. incapacity.

It is submitted that, if indeed it is the case that an individual may be found liable in the absence of moral fault, then the claims of this sub-theory to provide any moral underpinning must be therefore be flawed. The likelihood of this being the case is increased by the objective nature of the Scottish test for breach of the appropriate standard of care. Were the test entirely or largely subjective, then this argument would relinquish some of its force[82] because the test would be tailored more to the individual actor. As it is, however, we may note Atiyah's critique inter alia that the compensation payable bears no relation to the degree of fault nor to the means of the defendant.[83]

The question now becomes one of whether the same reasoning may also be applied to the law of medical

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[80]The Modern Law of Negligence, R. A. Buckley, London, Butterworths, 1988, at p. 24.

[81][1971] 2 Q.B. 691.

[82]Discussed in Glanville Williams, op. cit., at p.159 et seq.

[83]Atiyah's Accidents, Compensation and the Law, Peter Cane, fourth edition, Weidenfeld and Nicolson, 1987, at pp. 415 and 416 (Counts 1 and 2 in the indictment of the fault principle).

negligence. Some factors appear which may serve to render the test for the standard of care in medical negligence morally apposite. As we have seen, it was stated that an objection to the retributive theory of tort was that the individual defendant (or defender) might not have the capacity to comply with the duty, which in effect is a form of strict liability. In the medical context,[84] a qualified and duly registered doctor has sufficient qualifications, training and intelligence that we may be reasonably certain that he is intrinsically capable of satisfying the present standard of care. An additional factor is the element of "holding out" of professional medical skills, absent in many examples of common, non-professional liability for negligence, and which may serve to justify an informal presumption that this argument might not be open. It has been commented generally that,

> "[P]ractitioners are usually committed, or expected to be committed, to certain moral principles, which go beyond the general duty of honesty. They are expected to provide a high

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[84]And indeed perhaps all the contexts of liability for professional negligence.

standard of service for its own sake."[85]

The standard of care applicable to medical negligence is higher than the normal standard, but only inasmuch as it is based upon reasonable but comparable medical practice. This is because the ordinary man on the Glasgow omnibus would presumably make a poor general practitioner, for example. The legal test, and standard, it is suggested, are very similar but simply translated to the discipline of medicine. Any higher aspirations or idealism are likely to be the product of the professional training and calling than the substance of this legal test.

However, to leave the enquiry at this point would, it is submitted, be to leave it incomplete. As one might expect, the case law gives very little overt reference to, or explicit consideration of, any retributive or generally moral basis for the law of medical negligence. The essence of the leading Scottish test for medical negligence is that,

> "..it must be proved that there is a usual and normal practice; secondly it must be proved that the defender has not adopted that practice; and thirdly (and this is of crucial importance) it

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[85]Professional Negligence, R.M. Jackson and J. L. Powell, second edition, Sweet and Maxwell, 1987, at p. 1. This does not of course imply anything of necessity for the content of the duty of care, although perhaps it renders the moral basis of it a little more likely. It should be noted that the third edition of Jackson and Powell, Sweet and Maxwell, 1992, does not repeat the above but instead analyses the apparent formal distinguishing characteristics of a profession, no doubt in deference to the increasing number of callings seeking identification as such. Despite this, the present writer included the quotation from the second edition as aptly encapsulating the traditional professional ethos.

> must be established that the course the doctor adopted is one which no professional man of ordinary skill would have taken if he had been acting with ordinary care."[86]

Ultimately,[87] this too is a reasonably objective test[88] and therefore provides the basic potential for Coleman's objection to the retributive theory to apply to the law of medical negligence. The special difficulties, and moral connotations, of the attribution of legal fault to doctors were summarised in an English case in 1983:

> "[T]his claim reveals a disgraceful state of affairs. Where an injury is caused which never should have been caused. Common sense and natural justice indicate that some degree of compensation ought to be paid by someone. As the law stands, in order to obtain compensation an injured person is compelled to allege negligence against a surgeon who may, as in this case, be a careful, dedicated person of the highest skill and reputation. If ever there was a case in which some reasonable compromise was called for...and avoid the pillorying of a distinguished surgeon, this was such a case."[89]

Perhaps this was suggested by the comment in Atiyah's Accidents, Compensation and the Law[90] that,

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[86]Per Lord President Clyde, Hunter v. Hanley, 1955 S.C. 200, at p. 206. The question as to whether all cases of medical negligence are to be analysed as deviations from a notional norm is dealt with elsewhere.

[87]See also the more recent case of Moyes v. Lothian Health Board 1990 S.L.T. 444, an Outer House decision in which Lord Caplan approves Lord President Clyde's test in Hunter.

[88]A more objective version of it would involve raising the applicable standard to that of the highest-skilled professional in that field.

[89]Per Kilner-Brown J., in Ashcroft v. Mersey Regional Health Authority, (1983) 2 All E.R. 245, at p. 246a - 246b.

[90]Op. cit.

> "[N]either in law nor in morality is fault the only ground on which a person may be required to compensate another, although in the sphere with which we are mainly dealing the law at least generally recognizes no other."[91]

However, the case of Wilsher v. Essex Area Health Authority[92] must be considered in this context.[93] In Wilsher, one of the principal issues between the parties was whether the standard of care should be varied towards the subjective part of the spectrum in order, in effect to allow a junior doctor's inexperience to be a defence to an allegation of negligence. The Court of Appeal held the junior doctor not to have been negligent. This was despite his inexperience, which the court clearly said in general would not afford a defence to an allegation of negligence. In calling upon a more senior colleague, a registrar (who also did not notice the incorrect treatment of the

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[91]Atiyah's Accidents, Compensation and the Law, by Peter Cane, fourth edition, Weidenfeld and Nicolson, 1987, at p. 427.

[92][1986] 3 All E.R. 801 (C.A.): we are not concerned with the appeal to the House of Lords at this stage, as that dealt only with the issue of causation rather than the standard of care.

[93]As indeed might the case of Payne v. St. Helier Hospital Management Committee [1952] Current Law Year Book 2442, in which a casualty doctor wrongly diagnosed internal injuries in a patient kicked by a horse, negligently failing to call in a consultant as the former doctor was not capable of making the appropriate diagnostic examination.

patient)[94] the junior doctor was thus held to have discharged his duty of care. Two points should be noted. Firstly, the defendant in the case was the Area Health Authority as employer. It is difficult to see how the ascription of liability vicariously to the employer can comply with the requirements of the retributive theory. This is because, assuming that the Authority had discharged its duty to appoint suitably qualified and skilled medical staff, it has thereafter little direct control over the actual medical practice of such staff.[95] Therefore to make the defendant vicariously liable in such circumstances cannot satisfy the central requirement of a retributive basis for medical negligence.[96] Secondly, Wilsher laid down that inexperience was not a defence: as already considered, the test was primarily objective. Mustill L.J. in the Court of Appeal in the case of Wilsher v. Essex Area Health Authority stated as follows:

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[94]This was constituted by incorrect placing of a blood oxygen tension monitor which gave false readings and therefore induced the doctors to increase the level of oxygen applied to the infant plaintiff beyond that which was safe. However, the issue appealed to the House of Lords was solely that of causation, dealt with elsewhere in this thesis.

[95]Once appointments had been properly made, and assuming that systems were in place to regulate, monitor and perhaps keep employed doctors up-to-date with Department of Health circulars, direct liability would be very unlikely to arise.

[96]Unless perhaps the health authority sought indemnity from the doctor, which is unlikely. In any event, the professional indemnity insurance carried by doctors, and the introduction of Crown indemnity, militates against the retributive theory as the retribution is exacted partly or wholly against one who cannot be held morally responsible for the conduct in question.

> "[T]o my mind, this notion of a duty tailored to the actor, rather than to the act which he elects to perform, has no place in the law of tort. Indeed, the defendants did not contend that it could be justified by any reported authority on the general law of tort. Instead, it was suggested that the medical profession is a special case.....If the hospitals abstained from using inexperienced people, they could not staff their wards and theatres, and the junior staff could never learn....To my mind, it would be a false step to subordinate the legitimate expectation of the patient that he will receive from each person concerned with his care a degree of skill appropriate to the task which he undertakes to an understandable wish to minimise the psychological and financial pressures on hard-pressed young doctors....For my part, I prefer the third of the propositions which have been canvassed. This relates the duty of care, not to the individual, but to the post which he occupies. I would differentiate "post" from "rank" or "status". In a case such as the present, the standard is not just that of the averagely competent and well-informed junior houseman (or whatever the position of the doctor) but of such a person who fills a post in a unit offering a highly specialised service..."[97]

Essentially, it is submitted that this reinforces the primarily objective nature of the test for medical negligence and indeed strengthens this characteristic inasmuch as a junior doctor, who may de facto be unable to comply with the demands of the duty, will nevertheless be held to be in breach of it. It may thus be seen that any claim of the retributive theory to provide a moral basis for the law of medical negligence

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[97] Wilsher, [1986] 3 All E. R. at p. 813d - 813h; see Jones, op. cit., at pp. 85-90.

cannot be sustained, for it is open to the same criticism made generally by Coleman.

It is interesting to note that in modern scientific method, an important criterion of the validity of a theory is its falsifiability.[98] If an explanation is susceptible of testing in this manner, it is important to note that only one counter-example is required in order to falsify, or refute, the theory. With this in mind, let us proceed to consider the next potential moral basis for this part of the law of delict.[99] Before leaving retributivism, it is worth noting that even if its claims were sustained, Coleman states that,

> "...[W]e can penalize an individual's fault - moral or other - without the penalty taking the form of his being held liable for the costs of harms his fault occasions. In other words, even if the notions of moral fault and fault in torts converge so that every person who is at fault in torts is morally culpable, the retributive argument could not adequately explain why it is that the victim is compensated by his injurer. Indeed the retributive argument suggests a very different sort of means for allocating costs: namely, the "at fault" pool." "[100]

This raises a point to which the thesis will return in considering reform, namely that of general "severability", or as Coleman subsequently analyses it, the distinction

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[98]See, for example, Karl R. Popper, Conjectures and Refutations, Routledge and Kegan Paul, London, 1963.

[99]See, for example, Karl Popper, Poverty of Historicism, Routledge, Keegan and Paul Ltd, 1957, at pp. 132-134.

[100]Coleman, op. cit., at p. 375.

between grounds of rectification and modes of rectification.[101]

Responsibility Theory

Responsibility theory, as evaluated[102] as a moral basis for tort liability, is predicated principally upon the work of Epstein.[103] This theory accepts that the claim to moral justification of the fault principle, considered supra in the context of retributive theories, does not provide a moral basis for the fault principle.[104] The theory takes as its starting point that tort theory must be based upon "..common sense notions of individual responsibility".[105] Quite simply, as Coleman neatly encapsulates it,

> "[T]he moral weight which was to have been carried by the fault principle in the ill-fated Retributive Argument is to be borne instead by the causal condition. Not only would Epstein's approach....reduce, if not eliminate entirely, the role of fault in a just theory of liability;

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[101]See Coleman, Moral Theories of Torts: Their Scope and Limits: Part II, 1983 II Law and Philosophy 5, at p. 11 et seq.

[102]Discussed in Coleman, op. cit., p. 378 et seq.

[103]See, for example, A Theory of Strict Liability, Richard A. Epstein, 1973 (University of Chicago) Journal of Legal Studies 151.

[104]The difficulties raised in the general legal context by the concept of responsibility are discussed in Voluntary Acts and Responsible Agents, Bernard Williams, 1990 10 Oxford J. Legal Studies 1.

[105]Epstein, op. cit., at p. 151.

> it would provide a moral foundation for the much maligned rule of strict liability as well."[106]

At once, we may observe that this theory allows very little scope in attempting to discern a moral basis for the current law of medical negligence, for it seeks, prescriptively, to abolish a fundamental part of the present legal analysis of such cases, the fault principle. At the outset, therefore, this theory is severely fettered in its ability to explain or justify the existing law. The moral quality of the tortfeasor's act is irrelevant; it is the simple fact that he caused the damage or injury which justifies liability. This would, it is submitted, tend to produce even greater complications of policy in the definition and ascription of causal responsibility; Hart and Honore conclude that,

> "[W]hat we are really concerned to stress, therefore, is that there exist in the law of tort two radically different techniques for limiting responsibility, causal and non-causal, and that both of these should have a place in any workable system of law."[107]

However, let us consider the theory a little further. The essence of Epstein's thesis is that the causal consequences of a person's intentional action are those for which he should be responsible.[108] Notwithstanding the criticisms

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[106]Coleman, op. cit., at pp. 378-379.

[107]Causation in the Law, H.L.A. Hart and A.M. Honore, second edition, Oxford, 1985, at p. 307.

[108]For a discussion of causation and responsibility sparked by the Californian market-share product liability case of Sindell v. Abbott Laboratories (cited as 1980 607 P. 2d. 924 infra), see Causation and Corrective Justice: Does Tort Law Make Sense?

levelled at this by Coleman[109] and others,[110] severe difficulties in applying this to medical negligence are to be anticipated, precisely because the causal chain may not be clear, especially in a scientific and technical discipline such as the practice of medicine. Recent examples of this phenomenon include Wilsher,[111] Hotson v. East Berkshire Area Health Authority[112] and Clark v. MacLennan.[113] We may note, as does Coleman,[114] that the two theories considered above require the tortfeasor to make recompense to the victim. The penultimate approach which has been propounded as giving negligence a moral underlay is the reciprocity of risk theory, which includes pre-

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Larry A. Alexander, 1987 6 Law and Philosophy 1.

[109]Coleman argues that to make a defendant liable in this way allows the potential to render him liable inappropriately, i.e. inflexibly (his "strong" criticism); his "weak" criticism is that the theory may not ascribe liability where the defendant may not have caused the harm but nevertheless either is or ought to be held liable. It is also argued that causal responsibility and personal responsibility do not coincide, further reducing the viability of the theory in providing a moral basis for negligence. Coleman, op. cit. at pp. 379-381. An example of one of Coleman's criticisms is that examined above in the context of the retributive theory: vicarious liability.

[110]"The simple causation formula fails, for it disregards a significant requirement of fairness. Individuals should be held accountable only for unexcused actions. Any approach that disregards excuses hardly warrants approval as a just basis for shifting losses." George P. Fletcher, Synthesis in Tort Theory, 1983 II Law and Philosophy 63, at p. 72.

[111]Supra

[112][1987] A.C. 240 (H.L.)

[113][1983] 1 All E.R. 416

[114]Coleman, op. cit., at p. 383.

conditions for the imposition of liability under this head. The leading proponent of this approach is Fletcher;[115] once again the potential for it to justify or indeed even to explain the basis for the law of medical negligence is limited by the possibility of regarding it partly as normative rather than descriptive.[116]

Reciprocity of Risk

This analysis initially applies two tests. As its name suggests, firstly the tortfeasor must have imposed a risk upon the defendant which he did not, or would not, impose upon or accept himself: this is the idea of non-reciprocity and perhaps ultimately is traceable to the similar biblical injunction.[117] It is the basic test for the imposition of liability. An element of fairness is also emphasized at this point: the tortfeasor must have no acceptable excuse for having acted as he did. Should an excuse be absent, then the tortfeasor may justly be held

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[115]See, Fairness and Utility in Tort Theory, George P. Fletcher, 1972 Harvard Law Review 537, and The Search for Synthesis in Tort Theory, George P. Fletcher, 1983 II Law and Philosophy 63.

[116]Coleman, op. cit., at p. 385.

[117]"Therefore all things whatsoever ye would that men should do to you, do ye even so to them: for this is the law and the prophets." Holy Bible, London, Eyre & Spottiswoode Ltd. (no date of publication quoted); The Gospel According to St. Matthew, chapter 7, verse 12.

liable[118] (it being implicit that the tortfeasor must have "caused", by acceptable criteria, the damage, loss or injury). As regards the moral dimension in which we are principally interested, Coleman, arguing that the theory cannot account either for fault or strict liability, comments that:

> "...while the Reciprocity View makes the absence of an excuse a condition for liability to be imposed justly under both the fault or strict liability principles, in neither case is liability in fact defeasible by a showing by the defendant of a lack of defective motivation on his part."[119]

It has also been commented that,

> " "Even if a person admits that he occasionally makes a negligent mistake, how in the nature of things, can punishment for inadvertence serve to deter?" But if this question is meant as an argument, it rests on the old, mistaken identification of the "subjective element" involved in negligence with "a blank mind", whereas it is in fact a failure to exercise the capacity to advert to, and to think about and control, conduct and its risks. Surely we have plenty of empirical evidence to show that, as Professor Wechsler has said, "punishment supplies men with an additional motive to take care before acting, to use their faculties, and to draw upon their experience." Again there is no difficulty here peculiar to negligence, though of course we can doubt the efficacy of any punishment to deter any kind of offence"[120]

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[118]See Fairness and Utility in Tort Theory, George P. Fletcher, 1972 Harvard Law Review 537, at pp. 537 - 540.

[119]Coleman, op. cit., at p. 384.

[120]Punishment and Responsibility, H.L.A. Hart, op. cit., ch. VI (Negligence, Mens Rea and Criminal Responsibility), at pp. 156-157 (footnotes omitted).

It is submitted that this factor is crucial to the validity of a moral theory purporting to justify or explain the nature of tort. If the conduct of the tortfeasor is to be assessed irrespective of his moral or other motivation or capacity, then such an analysis is flawed. For, if the over-arching purpose of the law of tort is moral, how can it simultaneously omit this axiomatic and fundamental factor in the person whose conduct is being considered and evaluated? Again, the tortfeasor might be acting outwith his capacity, and therefore being judged against an impossible standard which again resembles strict liability and is open to criticism.[121] Coleman continues by demonstrating that in fact the reciprocity thesis is based upon a distributive justice model rather than a corrective justice one.[122] Thus, he says of the reciprocity view that,

> "..everyone has a right not to be harmed without being compensated. If we take Fletcher at his word, it is the fact that one has suffered harm that entitles one to recompense, not the fact that one's harm results from another's non-reciprocal risk taking. The principal that is supposed to impart moral significance on the criterion of non-reciprocity of risk actually has the effect of eliminating it. With non-reciprocity as a condition of liability out of

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[121]See inter alia, Strict Liability in Scotland, D.M. Walker, (1954) 66 J.R. 72; Punishment and Responsibility, H.L.A Hart, op. cit., ch. VI (Negligence, Mens Rea, and Criminal Responsibility); Jules Coleman, Moral Theories of Torts, Part I (op. cit.) principally at pp. 374-383; Part II (op. cit.) at pp. 14-15 and 26-29; cf. inter alia Richard A. Epstein, A Theory of Strict Liability, 1973 (University of Chicago) Journal of Legal Studies 152.

[122]Coleman, op. cit., part I, at pp. 388-389.

> the way, Fletcher's view collapses into Epstein's.."[123]

The present writer respectfully agrees with this criticism of the theory, to the effect that its claim to a moral content is ultimately not sufficiently sustainable.[124] So far as the law of medical negligence is concerned, it is further submitted that the reciprocity of risk analysis is satisfactory neither as a descriptive theory nor as a normative theory. In both cases, this is because the underlying nature of the transaction is not susceptible of translation to these terms. Whereas reciprocity has an immediate plausibility in the examples considered by Coleman, for example that of motor-car drivers accepting a background risk and then superimposing upon that an unacceptably high risk by careless driving,[125] the clinical situation in which the doctor is consulted by the patient is not an activity in which there is the basic parity of risk imposition before the transaction or event in question which is by implication required by the theory. The patient imposes no risk upon the doctor, although the doctor may well impose varying degrees of treatment or investigative risk upon the patient, to which the latter

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[123]Coleman, op. cit., part I, at p. 389.

[124]A detailed critical analysis of the harm aspect of the theory is made by M. Margaret Falls, at pp. 27-38 of an article entitled Retribution, Reciprocity, and Respect for Persons, 1987 6 Law and Philosophy 25.

[125]Coleman, op. cit., part I, at pp. 387-388.

consents, in the normal case. This furnishes little basis for the operation of the theory, unless perhaps a formula is employed which permits the doctor to impose risks up to a certain level and no more. This, of course, starts to resemble the current test for medical negligence and more fundamentally has moved away from the central concept of reciprocity. Thus in Hunter v. Hanley,[126] the forensic enquiry centred upon the actual conduct of the doctor at the time; there was little or no scope for the patient to impose risks upon the doctor reciprocally. The nature of the transaction was unilateral to the extent that the patient consulted the doctor and presumably expected the latter's reasonable endeavours to be used.[127]

Corrective Justice

The fourth and final general category under which it has been sought to provide a moral basis for negligence in the the law of tort is that of corrective justice. Such an approach has been most persuasively urged by Weinrib,[128] who proposes an Aristotelian corrective justice structure

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[126]1955 S.C. 200

[127]This might furnish a basis for a reciprocity formula, but, it is thought a somewhat artificial and unsatisfactory one.

[128]Toward a Moral Theory of Negligence Law, E. J. Weinrib, 1983 II Law and Philosophy 37.

infused by Kantian content.[129] It is this theory which prima facie carries the strongest claim to provide a moral basis for the law of negligence.[130]

The general corrective justice model first distinguishes between corrective, and distributive, justice. The latter is described as existing "..where a given resource is distributed among competing claimants in accordance with a ratio that states a criterion of merit".[131] Corrective justice is said to be based upon the assumption of the parties as equal before the occurrence of the allegedly negligent episode (so-called "antecedent equality") and, after this event, in restoring this prior state of affairs "by transferring resources from defendant to plaintiff so that the gain realized by the former is used to make up the loss realized by the latter".[132] However, even at the start of his argument Weinrib acknowledges the limitations of theories of corrective justice:

> "[T]he status of corrective justice as a form and not a principle of justice points to its limitations as a solvent of tort controversy. A corrective justice conception of negligence will not in itself justify preferring the current system of liability based on fault to a more

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[129]Weinrib, op. cit., Abstract, at p. 37.

[130]See also, Causation and Corrective Justice: Does Tort Law Make Sense? Larry A. Alexander, 1987 6 Law and Philosophy 1.

[131]Weinrib, op. cit., at p. 38.

[132]Weinrib, op. cit., at p. 38.

> comprehensive no-fault compensation scheme.[133] Inasmuch as compensation schemes implicate values of distributive justice, the decision between them and a corrective justice system must be made on the basis of considerations extrinsic to the forms of justice which they respectively embody. Moreover, since corrective justice is a matter of structure not substance, there may be no tort regime which uniquely satisfies its requirements....Corrective justice in itself is devoid of a specific content, which accordingly, must be sought elsewhere..."[134]

Coleman, in his excellent analysis of corrective justice theories[135] summarises these boundaries in this way:

> "...corrective or rectificatory justice is concerned with wrongful gains and losses. Rectification is...a matter of justice when it is necessary to protect a distribution of holdings (or entitlements) from distortions which arise from unjust enrichments or wrongful losses. The principle of corrective justice requires the annulment of both wrongful gains and losses."[136]

This clear statement is, however, only the first step in our discussion. We must also bear in mind Coleman's comment that,

> "[O]ne important claim that corrective justice cannot ground is that a faulty injurer who has secured no gain through his fault ought to be held liable in damages to his victim. The reason for that is quite simple. The concern of corrective justice is wrongful gains and losses. The faulty injurer we are imagining secures no gain: no gain, no liability as a matter of

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[133]This hardly justifies or explains, morally or otherwise, the fault principle in negligence. The present writer submits that the criticism of Coleman which is put forward by Weinrib (op. cit., at p. 39), in that the latter's conception of corrective justice allows wrongful gains and losses to be separated from the parties, is relevant.

[134]Weinrib, op. cit., at p. 40. The emphasis is added.

[135]Coleman, op. cit., part II.

[136]Coleman, op. cit., part II, at p. 6.

> corrective justice. To find the source of liability we must look elsewhere."[137]

It is thought that this variant has been correctly analysed; it is that which most closely resembles medical negligence. Thus far, however, we are not entitled to conclude that Weinrib's theory is unable to provide a moral basis either for negligence generally or medical negligence specifically. This is for two reasons. The first is whether Weinrib's model of corrective justice is sufficiently similar to that of Coleman as to bring the former's argument within the ambit of the latter's criticism. The second relates, of course, to the content of Weinrib's theory, and is considered below.

It is submitted that Weinrib's general characterisation of corrective justice is sufficiently similar to that discussed by Coleman that the same criticism applies to both. Coleman's working definition has already been set out; that of Weinrib is slightly different. He draws a distinction between Aristotelian corrective justice, in which the same gains and losses are required, but the crucial point is that there is always a nexus in the transaction between the plaintiff and the defendant. In other words, the payment of damages must be

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[137]Coleman, op. cit., part II, at p. 11. Weinrib states, op. cit., at p. 39 that "..the term "corrective" applies to the types of reasons for an arrangement rather than to an arrangement itself." (footnote omitted).

by the latter to the former,[138] assuming no complications such as contributory negligence. This is to be contrasted with what is described as the more modern version of corrective justice in which the gains and losses are no longer "anchored"[139] to their respective plaintiff and defendant[140] but can "float free"[141] of what previously were these attachments. The question raised is whether the objection by Coleman still holds good - but a logically subsequent issue is also raised. This, as has been adverted to briefly, refers to the structure of the medical negligence claim, in which it is difficult to identify any gain from his negligence accruing to the doctor.[142] This is in contrast, for example, to some of the examples discussed which concern unjust enrichment or other possibilities demonstrating a clear and tangible gain to the tortfeasor. Returning to the former, however, Weinrib describes his version of Aristotelian corrective justice as considering

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[138]Weinrib, op. cit., at p. 38.

[139]Weinrib, op. cit., at p. 39.

[140]Weinrib, op. cit., at p. 39.

[141]Weinrib, op. cit., at p. 39.

[142]Other than the benefit of non-compliance with the duty of care; it is thought that on balance this gain should be of insufficient weight to allow this theory to be applied to such cases. In any event, compared with the potential loss accruing to the victim in medical cases, and indeed the tangible gains often cited in example, e.g. of wrongful acquisition of property, it is argued that this may be disregarded. Cf. Weinrib, op. cit. at p. 54: "[B]oth interpretations locate the defendant's wrongful gain in the foregone burden of precautions."

> "..the position of the parties anterior to the transaction as equal, and it restores this antecedent equality by transferring resources from defendant to plaintiff so that the gain realized by the former is used to make up the loss suffered by the latter."[143]

The version of corrective justice discussed by Coleman differs only in this quality of the "detachability" of the gains and losses arising in the transaction under consideration. We may now attempt to determine the applicability of the analysis and criticism by Coleman to the work of Weinrib. It is submitted that the general criticism of corrective justice as allowing a moral analysis of negligence again fails. Coleman's distinction between grounds and modes of rectification,[144] and the criticism it contains, must apply to both these forms of corrective justice equally. Further, Weinrib states that

> "..for Aristotle corrective justice is a form of justice and not a principle of justice. It does not state a normative requirement which must be followed or pursued."[145]

It is also contended that the analysis of corresponding gains and losses, present in both types of corrective justice, would require an artificial analysis of a gain to be made in the normal case of medical negligence. It is submitted that the functioning of the law seriously undermines claims that corrective justice provides a moral

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[143]Weinrib, op. cit., at p. 38.

[144]Coleman, op. cit., at p. 11.

[145]Weinrib, op. cit., at p. 39; footnotes omitted. He also says that "[C]orrective justice is devoid of a specific content.."; op. cit., at p. 40.

basis for medical negligence law and even fault liability generally.

Despite these arguments, it is thought that the Kantian content advocated by Weinrib comes closest to providing a satisfactory moral basis for negligence.[146] As Weinrib puts it,

> "This is not to say that the content is a matter of exegesis from Kant's own writings, or is to be justified by the precise forms of universalisation which characterize the various forms of the Categorical Imperative. But it must refer to some notion of equal membership in the kingdom of ends and the consequent impermissibility of arbitrary self-preference. It must also eschew reference to the aggregation of individual utilities which is the hallmark of utilitarian justification."[147]

The descriptive analysis presented of the objective element in the test for breach of the standard of care is persuasive.[148] It demonstrates how a subjective standard would amount to a contravention of the Kantian principle of

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[146]It is beyond the scope of the present work to review in detail the content of Weinrib's theory, which utilises Kantian ideas to provide the requisite substantive content of the theory. Modern variants on Kantian theories of punishment are discussed in Retribution, Reciprocity, and Respect for Persons, M. Margaret Falls, 1987 6 Law and Philosophy 25.

[147]The theory is explicative as well as normative: "[N]ow there are two features of negligence which a Kantian theory must explain.." Weinrib, op. cit., at p. 50. He refers also (ibid.) to the intrinsic difficulties of a utilitarian system of justice: by definition that in concentrating upon the two individual parties to the dispute, the wider overall utilitarian goal is likely to be lost or diluted. However, the theory puts forward a Kantian approach which differs from utilitarianism and is less ambitious in its goals.

[148]Expounded op. cit., at pp. 50-53. This need not, however, detain us.

self-preference in conception, thus opening the way to a partly objective standard.[149] This view, that of the annulment of wrongful gains and losses, does fit in to the general structure of corrective justice, although that remains merely a structure and is easily able to accommodate such a proposition.[150] More specifically, Weinrib's interpretation of Kant is to the effect that the defendant should place himself in the position of the plaintiff, or the person likely to be affected by the prospective action. This bears a similarity to the general legal test of reasonable foreseeability of harm. At the point at which this "hypothetical" arises, the Kantian calculus is applied "and provides a means for assessing the propriety of the defendant's harm-causing action."[151] This is by considering whether "..the maxim of one's action becomes a universal law of nature, the individual imposes no law upon others which he would not impose upon himself and arrogates to himself no privilege which he would not allow to others."[152] Weinrib argues that it is this which simultaneously provides the moral content of the theory and the link between the plaintiff and defendant;[153]

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[149]Weinrib, op. cit., at p. 52.

[150]Weinrib, op. cit., at pp. 53-57, distinguishing Weinrib's application of Kantian philosophy from utilitarianism.

[151]Weinrib, op. cit., at p. 57.

[152]Weinrib, op. cit., at p. 50.

[153]Weinrib, op. cit., at p. 60.

> "..it provides a positive reason for shifting losses in accordance with it...[T]he wrongfulness of the action, consisting here of the defendant's self-preferential violation of the equality he ought to have accorded to the plaintiff, supplies a ground for the restoration of the antecedent equality which was wrongly disturbed."[154]

We must now determine whether this theory is able to provide a moral basis for the fault principle presently existing in the law of negligence, and specifically in medical negligence.

The first point is that the criticism made of the morally-based analysis in the context of retributive theories appears also to apply here. "[T]he fault in the doing need not exemplify a fault in the doer."[155]: the legal fault principle need not necessarily correspond with the existence of moral fault. It is also submitted that the analysis of the case of Wilsher v. Essex Area Health Authority[156] also suggests that the Kantian content theory does not provide a moral basis for the law of medical negligence.

An important aspect of whether this theory can provide a moral basis for negligence, and in particular medical negligence, is whether it is capable of explaining and justifying the principles involved in the law. We may consider the four oft-overlooked categories of tort, which

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[154]Weinrib, op. cit., at p. 60.

[155]Coleman, op. cit., part II, at p. 9.

[156][1986] 3 All E.R. 801

a morally based theory must support in this way. It is submitted that a moral theory, in order to explain or justify the current calculus of liability, must support each one, otherwise it does not require the tort/negligence system, but would equally support some other means of satisfying the claims involved.[157] They comprise, following Coleman's analysis,

> (1) the foundation of the claim;
> (2) the mode of rectification;
> (3) the character of rectification; and
> (4) the extent of rectification.[158]

These are stated in broad terms to cover tort law generally, but it is thought that they are also by definition applicable to the subcategory of negligence (and to medical negligence). Coleman explains[159] that the mode of rectification is the manner in which the unjust gains and losses are to be eliminated and the character of

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[157]Although not a question of the moral content of the theory, it may be observed in passing that to argue that Aristotelian corrective justice is required by a moral basis of tort, is, it is submitted, to pre-suppose that which requires to be established.

[158]Coleman, op. cit., at p. 12.

[159]Ibid.

rectification is whether a particular type of award is appropriate in all cases. Note that again there is a pre-supposition that a quantifiable gain has accrued to the tortfeasor. It is submitted that in medical negligence, the only gain so accruing is the benefit of ignoring reasonable precautions. Such a gain is disputable on grounds, it is suggested, (a) of triviality, certainly by comparison with the loss sustained by the patient, (b) of extreme difficulty of quantification and (c) of public policy, in that the admittedly slight implicit legitimation of failing to exercise due care should not be allowed to be included.

However, the two of Coleman's categories which merit particular consideration for our purposes are the first two. If in fact it is the criterion of assessment actually adopted, it is thought that Weinrib's application of the Categorical Imperative to negligence would provide a foundation of the claim that a compensable (sic) loss had been suffered.[160] Likewise, the tortfeasor, by his self-preference and its non-universalisable nature, caused a loss to the plaintiff. Although this analysis does establish liability on the part of the tortfeasor, again it does not, it is submitted, establish a necessary link between tortfeasor and victim in the payment of damages.

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[160]For a different approach to fault-based liability, see George P. Fletcher, Synthesis in Tort Theory, op. cit., at pp.74-81, employing a quasi-economic, quasi-utilitarian analysis.

As previously discussed, the entitlement and liability thus created might be satisfied by the use of a Calabresi-type "risk-pool" or a no-fault compensation scheme.

The further question, even assuming that these reservations about the general applicability of this theory did not exist, is whether it can explain the existing principles in the law of medical negligence.[161]

The Scottish test for medical negligence, laid down in Hunter v. Hanley,[162] has been set out already and is considered elsewhere. For present purposes, it is submitted that it does not correspond sufficiently to Weinrib's theory as to support the fault principle in the law of medical negligence. Firstly, the "universe" relevant to the application of the test would require to be restricted to comparable medical practitioners, in order to compare like with like. Another difficulty with applying Weinrib's theory to the medical sphere is that the law is framed to allow genuine differences of professional opinion. This might constitute a barrier to the criterion of universalisability. Further, the terms of the Scottish test (which it is submitted is similar to that applied in England) do not correspond with Weinrib's application of

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[161]It may be noted that in fact various different tests would meet the central requirement of universalisability in Weinrib's theory, but that the converse is not necessarily true, i.e. that the adoption of universalisability as the main criterion does not lead to the adoption of any particular formulation of the test.

[162]1955 S.C. 200

the Categorical Imperative, concerning essentially that which no doctor of ordinary skill would do. Merely because this test may not necessarily be inconsistent with such a broad general principle as the Categorical Imperative does not mean either that it corresponds to it, or indeed that it automatically validates or supports it. The standard employed is that of ordinary care, which in itself might not intrinsically be of a high enough standard to be universalised. Nor, again, is it easy to reconcile the vicarious liability of a health board with this theory. Application of this criterion thus might not lead to the correct or appropriate standard of care, and might even discourage the challenging of dubious but common medical practices by the courts. In more complex cases involving specialist units and hospitals, for example that of Wilsher, its adoption might also ultimately imperil the object of the exercise, if it were adjudged satisfactory that all levels of medical personnel were able to call in their next senior colleague in order to avoid a finding of negligence.[163] This would rapidly tailor the test to the efficiency of upward delegation by medical staff, and the degree of skill ultimately exercised by the harassed senior doctor at the apex of the hierarchy!

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[163]The attitude of the Court of Appeal to this would no doubt alter quickly were this commonplace, or in order to avoid a finding of negligence.

Conclusion

The writer finds Weinrib's application of the Categorical Imperative attractive; it appears to offer many useful descriptive and normative insights into the law.[164] Indeed, it is thought that this approach comes the closest of the various possibilities considered to providing a satisfactory moral basis underpinning the fault principle. Nevertheless, it is submitted that ultimately, reservations exist about its ability to justify or explain the fault principle consistently and morally, and that there are further difficulties in its application to the law of medical negligence.[165] In arguing that this debate discloses no acceptably satisfactory moral basis for the fault principle in medical negligence, the writer does not dispute that moral considerations are relevant,[166] and

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[164]A morally-based argument in favour of widening tort duties to include a duty to rescue is advanced by Weinrib in The Case for a Duty to rescue, 1980-81 90 Yale Law Journal 247.

[165]Idiosyncratic factors in medical negligence cases also include the apparent enthusiasm by the European Community for the introduction of a reversed burden of proof in medical negligence actions, reported recently in the British Medical Journal. The fear is also recorded there of health authorities (and boards) settling post-Crown indemnity litigation claims for reasons of economy, rather than fighting them. Both possibilities would, it is submitted, wreak havoc with a purported moral basis for the fault principle. See 1991 B.M.J. at p. 129.

[166]Little reference to morality is evident in the case-law of negligence. A possible example is the motive to injure in the intentional tort of conspiracy to injure; see inter alia Lonrho v. Shell Petroleum Ltd. [1982] A.C. 173. An example of a similar Scottish intentional delict is British Motor Trade Association v. Gray 1951 S.L.T. 247.

indeed important, generally in the law of tort and delict. One of the claims of morality to be concerned in this area of the law is the apparent perception that because of someone's responsibility for, or fault in, an accident, they should be held liable.[167] Indeed the view has been considered that any moral basis for the fault principle may in fact rest upon psychological mis-perceptions of the law and its role rather than a congruence of moral fault and legal fault.[168] Further, those moral characteristics which the fault principle may display, even if less than the full basis sought by the various general theories already considered, may be squandered by the harsh practical realities of litigation, both in procedural terms as well as in substantive law.[169]

In conclusion, therefore, it appears that no clear or consistent moral basis for the fault principle may be demonstrated without reservation. Such moral considerations as undoubtedly do exist do not necessarily appear to require the construction of the present analysis

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[167]Perceptions of liability may be determined by the availability of a legal remedy. See ch. 4 (by Sally Lloyd-Bostock), in Compensation and Support for Illness and Injury, D. Harris et al., Oxford Socio-Legal Studies, Clarendon Press, Oxford, 1984.

[168]See Sally Lloyd-Bostock, op. cit., (ch. 4) at pp. 140-161.

[169]See generally, Hard Bargaining: Out of Court Settlements in Personal Injury Actions, Hazel Genn, Clarendon Press, Oxford, 1987, especially chs. 6 and 7.

and calculus of liability.[170] If this broad proposition must be stated with a certain tentativeness, we may be a little more confident of its applicability to the law of medical negligence. It is hoped that it has been shown that the professional nature of this liability, the underlying test and discipline involved in practice generally seriously undermine the claims for fault's having a truly moral basis.[171] Nor, however, would the writer assent to the broad proposition that morality is, or even should be, irrelevant to a discipline such as law, which must by definition be concerned with justice and perceptions of moral right and wrong, however they are clothed in the legal process.

The aims of the system, and the best means of achieving them for the law of medical negligence, in the argued absence of a satisfactory tie to the existing fault principle, will be considered infra in this thesis in the context of reform.

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[170]Analogous reasoning is evident in Liability for Failing to Rescue, Theodore M. Benditt, 1982 I Law and Philosophy 391.

[171]See Jones, Medical Negligence, cit. supra, para. 3.77 (at pp. 86-87; footnote omitted): "[A] finding of negligence...does not necessarily mean that the defendant was morally blameworthy, since negligence is treated as an objective measure of a standard of conduct without any inquiry into why a defendant failed to achieve that standard, as might occur in a court of morals."

Part III

Chapter V

Causation

Introduction

Application of the fault principle to cases of medical negligence is, it is submitted, relatively intelligible to the judge, lawyer or other (non-medical) layman. This, it is conceived, is partly because the reasoning and patterns of logic which the doctor considers and evaluates in reaching a clinical decision are relatively easily understood, reconstructed and analysed subsequently, either by doctors or others. The conduct of a fellow professional, even in a scientific discipline, is perhaps more amenable to this forensic assessment than the content of the discipline itself. By contrast, it is suggested that the issue of causation is different.[1] This is partly because a causative process may not in itself be scientifically understood,[2] and partly because consideration of the causal issues raised by the sequelae of negligence are unlikely to form part of the doctor's clinical calculus; the consequences of such a lapse might not, scientifically, even be possible to anticipate. Both of

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[1]See generally A.M. Dugdale and K. M. Stanton, Professional Negligence, op. cit., at pp. 306 - 308.

[2]See Compensating Victims of Diseases, J. Stapleton, 1985 5 Oxford J. Legal Stud. 248.

these may render the court's examination of causal issues problematic, although the general rules as to foreseeability and remoteness apply to these cases as much as to non-medical ones. Legal doctrines of causation, particularly in relation to medical and scientific matters, have been subjected to fundamental and systematic extended criticism,[3] and causal difficulties in the law appear to arise most frequently in relation to scientific matters.[4]

The development of the fault principle, and its extension to new areas such as specialist hospital teams,

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[3]An extended American-based critique which finds the present underpinnings unsatisfactory is made by S.N. Pincus, in Progress on the Causal Chain Gang: Some Approaches to Causation in Tort Law and Steps toward a Linguistic Analysis, 1986 24 Osgoode Hall L.J. 961. The main other materials in this large area are: Jane Stapleton, The Gist of Negligence, 1988 104 L.Q.R. 213 and 389, Law, Causation and Common Sense, 1988 8 Oxford J. Legal Studies 111 and Disease and the Compensation Debate, Clarendon Press, Oxford, 1986 (chapter 3 deals with cause in fact, but references to causation in the book are too numerous to detail); generally H.L.A. Hart and Tony Honore, Causation in the Law, second edition, Clarendon Press, Oxford, 1985; Atiyah's Accidents, Compensation and the Law, Peter Cane, second edition, 1987, Weidenfeld and Nicolson (especially chapter 4, on causation and remoteness); A Step Forward in Factual Causation, E. J. Weinrib, [1975] 38 M.L.R. 518; Proof of Causation in Medical Negligence Cases, J. G. Logie, 1988 S.L.T. (News) 25 and Further Reflections on Medical Causation, A. F. Phillips, 1988 S.L.T. (News) 325 and generally, Radiation: proving the causal link with cancer, D. Brahams, 1988 N.L.J. 570.

[4]Causation in Toxic Torts: Burden of Proof, Standards of Persuasion, and Statistical Evidence, S. Gold, 1986 96 Yale L.J. 376, at pp. 376-377; the use of statistical evidence and its consequences are critically examined in the context of the so-called toxic torts. The adaptation and response of U.S. law generally to the rehabilitation of toxic waste sites is discussed in The Gorilla in the Closet: Joint and Several Liability and the Cleanup of Toxic Waste Sites, W.R. Wilkerson, T.W. Church, 1989 11 Law and Policy 425. See also Toxic Torts, C. Pugh, M. Day, 1991 N.L.J. 1549.

has been relatively straightforward and has retained almost entirely uninfringed those principles set out in Hunter v. Hanley.[5] It is submitted that this is not the case regarding causal principles, which have been subject at times to far greater challenge.[6]

This chapter seeks to argue that the causal principles embodied in medical negligence cases are unsatisfactory. They do not take into account any deficiencies in scientific knowledge, which, in view of the recently-emphasised strictness of the law, tend to work injustice against the pursuer. However, it is also suggested that any reform redressing the balance in favour of the pursuer, but within the scope of the present action, would tend to be equally unsatisfactory. It might still have the effect of holding as established a dubious, or untrue, causal fact which was not capable of being ascertained. This would be equally unsatisfactory whether working an injustice to a defender or a pursuer. This argument, together with the preceding chapters on the standard of care, it is hoped explain sufficiently the need for the reform. It is followed by proposals which are submitted to assist in overcoming these inherent difficulties. The chapter

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[5]Supra.

[6]See p. 102 et seq., Atiyah's Accidents, Compensation and the Law, fourth edition, Peter Cane, Weidenfeld and Nicolson, London, 1987, Proof of Causation in Medical Negligence Cases, J.G. Logie, supra, and Further Reflections on Medical Causation, A.F. Phillips, supra.

therefore commences with a brief exposition and consideration of the relevant authorities.[7]

Causal Principles

The general principle of causation in the law of delict and tort may, conveniently, be illustrated by reference to a case of medical negligence, that of Barnett v. Chelsea and Kensington Hospital Management Committee.[8] Three workmen had arrived at a hospital casualty unit for which the defendants were responsible, complaining of vomiting and feeling ill. They had been drinking tea. The casualty doctor, who was only informed of the men's condition by telephone and did not examine them, advised them to go home and call in their own doctors, i.e. their general practitioners. The men went home, one of them subsequently dying of poisoning by arsenic which had been present in the tea. The significance of the case is not that the casualty doctor had in fact not exercised the skill and care which the hospital's unit held itself out as providing, although this was the case. Rather it was because the patient would have died anyway, even if he had been treated timeously and properly: no harm was therefore causally attributable to

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[7]For an excellent introductory discussion of general causation issues in tort, see ch. 3 (Remoteness of Damage) in The Modern Law of Negligence, R. Buckley, Butterworths, 1988.

[8][1968] 1 All E.R. 1068

the negligence.

We may sum this up "deceptively simply"[9] by saying that a pursuer or a plaintiff must prove, on the balance of probabilities, that the breach of duty caused the loss concerned in the action.[10] The concept is apparently based upon notions of responsibility for one's actions.[11] More specifically, causation is often analysed into two questions, both of which must be satisfied if the pursuer is to recover damages. The first is the threshold test of "but for", or sine qua non. In the case of Barnett, the doctor's conduct could not be said to have been a factor without which the harm would not have occurred. Employing the standard analysis in delictual cases, thus the plaintiff would not even have surmounted successfully the preliminary causal hurdle.

The second question is that of the causa causans.[12] This is the "legal" or perhaps "proximate"[13] cause - that

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[9]Atiyah's Accidents, Compensation and the Law, Peter Cane, fourth edition, Weidenfeld and Nicholson, 1987, at p. 94.

[10]Charlesworth and Percy on Negligence, seventh edition, R. Percy, Sweet and Maxwell, 1983, at pp. 318-319.

[11]Professional Negligence, A.M. Dugdale and K.M. Stanton, second edition, 1989, Butterworths, at p. 295. Clearly, vicarious liability would be an exception to this principle.

[12]Always assuming that the head of damage is recoverable: Hotson v. East Berkshire Area Health Authority [1987] A.C. 750, considered infra.

[13]See discussion at p. 263 et seq., (chapter 7, Proximate Cause) in Prosser and Keeton on the Law of Torts, ed. W. P. Keeton, fifth edition, 1984, West Publishing Co., Minnesota.

which the law ascribes as the actual, legal[14] or common-sense cause of the harm, again assessed according to the likely view of the "..man in the street..".[15] Its description in these terms suggests, correctly, that its analysis is not always a matter of certainty or indeed clarity![16] Nor are all cases necessarily susceptible of analysis in this way,[17] and medical cases are likely to be more difficult than most owing to the limitations of knowledge and the attribution of symptoms and conditions from which the pursuer would be likely already to be suffering.[18] It may be objected that some of the cases mentioned in this analysis are not specifically ones of medical negligence. Whilst this is undeniable, those discussed nevertheless do deal with issues of medical

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[14]Perhaps with a degree of circularity.

[15]Per Lord Wright in Yorkshire Dale Steamship Co. Ltd. v. Minister of War Transport (re The Coxwold) [1942] A.C. 691 at p. 706.

[16]H. L. A. Hart and Tony Honore refer to a "cloud of causal metaphors" in Causation in the Law, second edition, Clarendon Press, 1985, at p. 88; their sometimes atomistic analysis of the case-law may be considered in the light of Lord Diplock's dictum in Lambert v. Lewis [1981] 1 All E.R. 1185 at p. 1189, that such an approach "presents the danger of so blinding the court with case-law that it has difficulty seeing the wood of legal principle for the trees of paraphrase". Atiyah's Accidents, Compensation and the Law, op. cit. (see p. 102 et seq.) adopts the bipartite analysis employed here, and criticises the Hart and Honore approach ibid.

[17]E.g. Fitzgerald v. Lane [1987] 2 All E.R. 455; Baker v. Willoughby [1969] 3 All E.R. 1528; Jobling v. Associated Dairies [1981] 2 All E.R. 752.

[18]E.g. the case of Barnett, supra.

causation, even though arising for example in reparation claims against industrial employers. In rebuttal of this point, it is argued firstly that similar issues do arise in medical cases, some of which might be conceptually almost identical, and secondly that the courts will be likely to decide causal issues in medical negligence cases in a similarly strict fashion. If this is correct, such cases are therefore thought to be relevant.

In considering the cases and principles[19] applicable to causation in this area, we may divide them into categories according to the underlying nature of the causal issues involved.[20] It is submitted that the recent House of Lords cases in particular demonstrate a consistently strict approach to the traditional burden of causal proof upon plaintiff and pursuer irrespective of category. The first and most straightforward class is what we may term "simple" or "linear" causation, perhaps suggesting the common metaphor of the causal chain.[21] This category is so-called because the causal enquiry is straightforward, i.e.

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[19]See Remoteness: Culpability and Compensation, D.M. Walker, 1976 J.R. 245.

[20]It may be noted that cases of medical negligence raising causal questions tend not to involve questions of foreseeability and remoteness, although these matters are in principle no less relevant in these cases.

[21]Cf. Hart and Honore, op. cit., at p. 72: "[I]t is easy...to be misled by the natural metaphor of a causal "chain", which may lead us to think that the causal process consists of a series of single events each of which is dependent upon (would not have occurred without) its predecessor in the "chain" and so is dependent upon the initiating action or event."

uncomplicated by multiple causes of any description. The second category concerns cumulative multiple causes, and the third, mutually exclusive multiple causes.[22] A related issue which either requires a discrete category or fits uneasily into the first one as a threshold question therein, is whether the loss of a chance of recovery should sound in damages; it is proposed, as a matter of practicality, to deal with this separately as a final category. It also raises fundamental questions such as the "all or nothing" nature of causation which in turn affect all these categories.

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[22]Despite the discussion in Hart and Honore on Causation (op. cit.), this analysis and terminology have previously been used by Jane Stapleton (Disease and the Compensation Debate, Clarendon Press, Oxford, 1986, p. 37 et seq.) and W. J. Stewart (A Casebook on Delict, W. Green/Sweet & Maxwell, 1991, at p.154). See also Multiple Causes, at pp. 176-177, in The Law of Torts, J. Fleming, seventh edition, Law Book Company Ltd.

Simple Causation[23]

A difficulty inherent in the concept of simple causation[24] is in satisfactorily distinguishing it from multiple causation cases in which there are two identifiable possible causes of the harm.[25] For, if the harm complained of[26] cannot be shown to be the legal cause, then some other cause, be it merely an "accident", must underly the harm. Thus, all cases involve multiple, in the sense of at least two, possible causes.[27] However, it is suggested that the cases advanced under this heading give a beneficial indication of some of the reasoning in, and attitude of,

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[23]Consent cases, in which it must be shown that the pursuer would not have consented to treatment had he/she been warned of the risks, are thought to come under this category. They are not therefore discussed separately. They include the following: Chatterton v. Gerson [1981] 1 All E.R. 257 and Goorkani v. Tayside Health Board (1990 G.W.D. 6-331; Lord Cameron.) It seems that patients need not be warned of remote or unreasonable risks, in the opinion of the doctor: Moyes v. Lothian Health Board 1990 S.L.T. 444. For discussion of Chatterton, see inter alia p. 95 (ch. 5, Consent) et seq. in Medicine, Morals and the Law, S. McLean and G. Maher, Gower, 1983.

[24]Or "monocausality".

[25]Causal analyses may be also be couched in terms of potentially tortious risk and background risk. See J. Stapleton, The Gist of Negligence, (1988) 104 L.Q.R. 389 at p. 390 et seq.

[26]If there is no harm, then by definition there can be no claim for damages in tort or delict.

[27]See, for example, Loveday v. Renton and Another, Times Law Report, 31 March 1988, regarding the causal effect of pertussis vaccine in relation to brain damage in young children. The plaintiff was unable to satisfy the burden of proof.

the courts in relation to such questions. Inasmuch as the "but for" test of causation cannot be satisfied by the pursuer or plaintiff, these cases are less-inaccurately termed simple causation than those in which the actual existence of two competing causal pathways may be identified with certainty.[28] As has been commented, the accumulation of aetiological knowledge tends to be slow and haphazard, adding another layer to the difficulties of plaintiff or pursuer.[29]

One illustration of simple causation already considered is that of Barnett, supra. Another is the well-known case of Kay's Tutor v. Ayrshire and Arran Health Board.[30] Here, the pursuer was held ultimately unable to surmount the primary causal hurdle of sine qua non;[31] nor

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[28]See the analysis of the balance of probabilities test, in relation to causation, in Disease and the Compensation Debate, J. Stapleton, Clarendon Press, Oxford, 1986, at p. 38 et seq. The difficulties identified by her in relation to statistical evidence and proof of occupational disease arguably also apply to the disentangling of complications arising from negligent and non-negligent medical treatment.

[29]J. Stapleton, op. cit., at p. 42.

[30]1987 S.L.T. 577

[31]Of spatial and indeed temporal necessity, the causal concepts extant will be discussed primarily in terms of the "but for" test and the legal cause. It is submitted that applying the type of analysis propounded by H.L.A. Hart and A.M. Honore in Causation and the Law, second edition, Clarendon Press, Oxford, 1985 (i.e. that these concepts are inapposite and should be substituted by consideration of when, and in what categories, the courts allow recovery) in fact adds little to a discussion of the effect of scientific knowledge upon the causal rules often formulated in terms of this traditional two-stage test. (See, for example, Hart and Honore, op. cit., at p. 109 et seq. (Chapter V: Causation and Sine Qua Non)).

did the expert evidence support the pursuer's contention that the negligent, gross overdose of penicillin could have partially caused the harm to the pursuer's son.[32] A known sequela of the meningitis from which the pursuer's son was already suffering, this harm (profound bilateral deafness) was in effect held by default to be caused by the meningitis which existed prior to the negligent treatment.[33] It was the absence of evidence showing that the overdose could have materially contributed to the harm which distinguished the case from McGhee v. National Coal Board.[34]

For the present, it may be noted that all the courts involved, apart from the Lord Ordinary (Davidson) in the Court of Session, took a strict view of the issue.[35] No judicial relaxation of the burden of proof upon the pursuer was countenanced, and the strong influence of expert

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[32]A more recent case to similar effect is Ingram v. Ritchie 1989 G.W.D. 27-1217 (Lord Prosser), involving the causal effect of a low-dose contraceptive pill on a cigarette smoker aged 35 who suffered a stroke shortly thereafter.

[33]This was partly because of the medical evidence, which showed that deafness could be caused by meningitis, but it is submitted that a very material contribution was made by the operation of the legal onus of proof.

[34]In which a material increase in risk was held sufficient; 1973 S.C. (H.L.) 37.

[35]Lord President Emslie gives a full, critical account of the Lord Ordinary's approach, which used the latter's own idiosyncratic and partially unsupported analysis of the evidence at pp. 436C - 440L in the report of the defenders' reclaiming motion to the First Division (Kay, 1986 S.L.T., at p. 435). The House of Lords agreed unanimously with the Court of Session ([1987] 2 All E.R. 417).

evidence in medical negligence cases was bolstered.[36] Furthermore, there appeared to be little if any evidence to support the pursuer's argument that the overdose might have caused or contributed to neurological damage[37] manifesting itself as deafness. The court's view was not one of scientific causal agnosticism, therefore, but that there was negligible evidence in favour of the pursuer's argument. Although the evidence ultimately was insufficient to support the pursuer's case, the approach taken by the Court of Session may be contrasted with that in the Scottish criminal cases of Khaliq v. H.M.A.[38] and Ulhaq v. H.M.A.[39], in which the pre-existing causal rules regarding supply and administration of dangerous substances were arguably relaxed significantly in order to convict the accused.[40]

The House of Lords' consideration of the appeal in Kay turned largely upon the expert evidence, save for the

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[36]Per Lord MacKay of Clashfern in Kay, [1987] 2 All E.R. at p. 422b.

[37]Compare Loveday v. Renton and Another, Q.B.D., Times Law Report, March 31, 1988, on the issue of whether pertussis vaccine could cause brain damage in children. The balance of probabilities test was not satisfied by the plaintiffs in this case. See Whooping Cough Vaccine on Trial Again, C. Dyer, 1987 295 B.M.J. 1053.

[38]1984 S.L.T. 137

[39]1991 S.L.T. 614

[40]See inter alia Scots Criminal Law and Aids, L. Farmer et al., 1987 S.L.T. 389 and also A Critique of Criminal Causation, A. Norrie, 1991 54 M.L.R. 685.

occasional distinguishing of McGhee on the grounds that the negligent conduct was not scientifically known as a possible cause of the harm.[41] Nevertheless, it is clear that no relaxation of the interpretation of the evidence was countenanced. This was despite certain ambiguities and difficulties in the opinions.[42] The writer would only seek to add that he agrees with Logie that the apparently retrospective reasoning regarding the patient's cerebro-spinal fluid sugar level was unsatisfactory - if not unwarranted.[43] Since this crucial evidence was unascertainable one way or the other, it is respectfully submitted that their Lordships should either have proceeded solely upon an explicitly statistical basis,[44] or have declared some degree of agnosticism as a result. The writer submits that, notwithstanding the strength of the defenders' evidence as to the incidence of deafness in meningitis, their Lordships' analyses are significantly

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[41]E.g. per Lord Keith, Kay, supra, at p. 421b - 421c.

[42]See Proof of Causation in Medical Negligence Cases, J. G. Logie, 1988 S.L.T. (News) 25 at pp. 25 - 27.

[43]Kay, supra, opinion of Lord Keith at p. 420g; the inference mentioned by his Lordship is presumably that the witness would have recalled the C.S.F. sugar level had it been (at or) above the normal level. It is submitted that this is a somewhat slender balance of probabilities upon which to base such an important supposition. See Logie's discussion of this, op. cit., at p. 26.

[44]I.e. expanding and explaining the expert's statement that meningitis was very likely to have caused deafness and that penicillin-induced deafness was unknown. (See opinion of Lord Ackner, Kay, supra, at pp. 426b - 427d).

based upon the onus of proof, with less emphasis being placed upon the inadequacy of the pursuer's expert evidence. Nonetheless, it is thought that the correctness of this decision, according to the law as it stood, must be conceded. This correctness may be unfortunate in terms of its public (mis-)perception, and the writer seeks to demonstrate in the light of other cases that the law's approach to scientific causation is unsatisfactory.

Mutually Exclusive Multiple Causes[45]

Multiple causation[46] includes cases in which there are two or more well-recognised possible causes, but scientific or other difficulty supervenes in attempting to evaluate their respective contributions to the harm.[47] The causes may be discrete or by a single causal agent of concurrently delictual and innocent provenance. The onus of proof is likely to become crucial in these cases. This category is discussed prior to that of cumulative multiple causes because, it is thought, the latter constitute more involved questions for which the present discussion may form a useful basis.[48] Where scientific or medical evidence cannot paint a full or clear picture, the courts seem generally to have considered this as an "evidential gap" which "..was the product of an imperfect state of medical knowledge and

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[45]A novus actus interveniens would be considered under this heading, as a defender might well seek to argue that it was a separate cause excluding his or her alleged causal responsibility.

[46]See generally, The Law of Torts, J. G. Fleming, seventh edition, Law Book Company, 1987 at pp. 176 - 177; The Law of Torts, Prosser and Keeton, fifth edition, West Publ. Co., 1984 at p. 263 et seq., and Disease and the Compensation Debate, J. Stapleton, Clarendon Press, 1986 at p. 37 et seq.

[47]Cf. Kay, supra.

[48]Dividing multiple causes in this way may pre-suppose that enough is known about a cause as to justify its classification. It is submitted that a degree of common-sense is unavoidable in employing the proposed taxonomy.

the view now taken by the courts is that such a gap can only be bridged where the available evidence is sufficiently strong to allow causation to be inferred."[49] However, it is submitted that one of the principal cases to be considered is Wilsher itself.[50] The decision in Clark v. McLennan,[51] which allowed a shift in the onus of proof to the defender, must be read subject to Wilsher, although it has been argued that the narrowing effect of the latter upon it is less than might be thought.[52]

However, the case of Wilsher is more recent, more authoritative and a more extreme example of mutually exclusive multiple causation. For all these reasons it is more instructive than Clark.

The infant plaintiff Martin Wilsher was born very prematurely, with all the associated serious risks to his

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[49]A.M. Dugdale and K. M. Stanton, Professional Negligence, op. cit., at p. 307. An excellent account of the application of McGhee-type reasoning to Fitzgerald v. Lane [1987] 2 All E.R. 455 is given ibid., pp. 307 - 308 (the causation issue was not discussed by their Lordships when the case was subsequently appealed). As the learned authors comment, it is difficult to be confident that the same approach could now be applied after Wilsher.

[50][1988] 1 All E.R. 871 (H.L.). It seems that the case involved mutually exclusive, or alternative, causes. Despite the fact that McGhee involved cumulative causes, it was still considered in Wilsher. As cases involving different modes of causation are not in practice subdivided, perhaps the common law of causation should ultimately be considered a many-dimensional whole.

[51][1983] 1 All E.R. 416

[52]Further Reflections on Medical Causation, A. F. Phillips, 1988 S.L.T. (News) 325.

health[53] and development. He required additional oxygen, but to do this it was necessary to measure and to monitor his blood oxygen tension. An electronic measuring sensor incorporated in a catheter was thus inserted. Unfortunately, this was into a vein rather than an artery. As a result of the misleading information thereby generated, an excessive amount of oxygen was administered.[54] It was this, the plaintiff alleged, which caused his retrolental fibroplasia ("R.L.F.") - a condition which left him practically blind.

The first causal argument surfacing in Wilsher was the effect of the prior authorities. Inasmuch as the judge at first instance in Wilsher, Peter Pain J., had combined or eased the separate establishment by the pursuer of the breach of duty and causation, the Court of Appeal held that this could not be accepted.[55] Nevertheless, it was held by majority that he had satisfied the test.[56] Thus the

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[53]"His prospects of survival were very poor: according to one estimate they were as low as one chance in five." Per Mustill L.J. in Wilsher [1986] 3 All E.R. (C.A.) at p. 803.

[54]A full account and explanation of the medical management of the plaintiff's case may be found in the opinion of Mustill L.J. in the Court of Appeal (ibid.).

[55]Per Mustill L.J. ibid. at p. 815e - g; by implication from the opinion of Glidewell L.J. at p. 832c - g. Sir Nicolas Browne-Wilkinson V.-C. disagreed on the causation issue, holding that to accept that the plaintiff had established this point entailed an unwarrantable extension of the previous law. See pp. 834f - 835j ibid.

[56]I.e. based upon the existing case-law, in this context referring to McGhee. See Mustill L.J. ibid. at p. 828g and 829b; he draws a distinction between McGhee and Wilsher at p. 828h - 829d, but considers the evidence sufficient to bring the

causation issue was decided the same way as in the court of first instance, but inter alia upon a differing interpretation of the prior case-law.[57] However, the most significant issue which emerged in the evidence was that several different causal pathways existed, any one of which might have caused the R.L.F.,[58] and it is this which is central to our present enquiry. Sir Nicolas Browne-Wilkinson V.-C. explained it with admirable clarity:

> "[B]ut no one can tell in this case whether excess oxygen did or did not cause or contribute to the RLF suffered by the plaintiff. The plaintiff's RLF may have been caused by some completely different agent or agents, e.g. hypercarbia, intraventricular haemhorrhage, apnoea or patent ductus arteriosus. In addition to oxygen, each of these conditions has been implicated as a possible cause of RLF. This baby suffered from each of those conditions at various times during the first two months of his life. There is no satisfactory evidence that excess oxygen is more likely than any of those other four candidates to have caused RLF in this baby. To my mind, the occurrence of RLF following a failure to take a necessary precaution to prevent excess oxygen causing RLF provides no evidence and raises no presumption that it was excess oxygen rather than one or more of the four other

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plaintiff within the rule. Glidewell L.J. said that "..I am in the end in agreement with Mustill L.J. that the plaintiff has proved sufficient facts to come within the principle of McGhee,...,and thus to succeed." (p. 831h). The Vice-Chancellor dissented, considering the facts of McGhee to rule out the use of analogical argument (pp. 834f - 835j).

[57]McGhee will be dealt with infra; for present purposes it is not yet necessary to consider it in detail. Describing the Court of Appeal's judgment as "Ending "forensic blind man's buff" " was premature. (in C. Dyer, Medicolegal, 1987 294 B.M.J. 1407.)

[58]Per Mustill L.J. ibid. at p. 828j.

possible agents which caused or contributed to RLF in this case."[59]

We may now consider the appeal in Wilsher to the House of Lords, solely upon the question of causation. As is well-known, the majority view of the Court of Appeal was reversed, the dissenting opinion of the Vice-Chancellor being approved. It was held unanimously that the burden of proof upon the plaintiff could not be relaxed in the face of what was not so much an evidential gap[60] as a conflict of expert evidence. Some doubt was expressed as to the ability of the court to determine such an issue.[61] The effect was that the plaintiff had been unable to establish, as was required, which of the five possible differing factors had actually caused the R.L.F. One debatable cause out of five was held not to constitute a material contribution (or a material increase in risk).[62]

Counsel for the plaintiff had also sought to rely upon the case of McGhee, to the effect that the negligent causing of a material increase in risk of harm was sufficient to discharge the onus. This did not succeed, and its reasoning was distinguished: it involved a single causative agent, brick dust. Its (pre-existing) presence

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[59]Ibid., at pp. 834h - 835a.

[60]As appeared to be the case in McGhee, infra.

[61]Per Lord Bridge of Harwich, [1988] 2 W.L.R. at p. 570G - H.

[62]See infra.

on the pursuer's skin was lengthened by reason of the defenders' breach of duty. No other causative agent was implicated. The case has been the subject of criticism, Wilson commenting as follows: "[I]t is no doubt easy to pass from saying that X increased the risk of Y happening to saying that it is probable that X caused Y, but nevertheless it is a step and, as Lord Wilberforce pointed out in McGhee, it is the step which the witnesses refused to take in that case."[63]

In Wilsher, however, four other possible agents were also present, and there was a conflict of expert testimony over whether that in question was indeed capable of causing the harm. Although McGhee was not disapproved (it being inappropriate to overrule it) it was described as laying down no new principle of law and thereby in effect confined to its own facts:[64]

> "[O]n the contrary, it affirmed the principle that the onus of proving causation lies on the pursuer or plaintiff. Adopting a robust and pragmatic approach to the undisputed primary facts of the case, the majority concluded that it was a legitimate inference of fact that the defenders' negligence had materially contributed to the pursuer's injury. The decision, in my opinion, is of no greater significance than that and to attempt to extract from it some esoteric principle which in some way modifies, as a matter of law, the nature of the burden of proof of causation which a pursuer or plaintiff must

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[63]A Note on Causation, W.A. Wilson, 1976 S.L.T. 193 at p. 195.

[64]Per Lord Bridge, at p. 569F et seq.: "The conclusion I draw...is that McGhee...laid down no new principle of law whatever.".

> discharge once he has established a relevant breach of duty is a fruitless one."[65]

It is submitted that this clearly and authoritatively indicates the courts' attitudes to proof of causation in cases of mutually exclusive multiple causes. It is also consistent with the approach in the case of Kay, supra. We may summarise it to the effect that the pursuer or plaintiff must still establish on the balance of probabilities which of the multiple possibilities caused, or materially contributed to,[66] the harm suffered. Although any reduction in, or reversal of, the burden of proof based upon McGhee or Clark has been short-lived, it may be possible to make a "bridging" inference - but only in cases which admit evidentially of little doubt and in which perhaps it is the detail rather than the substance of scientific explanation which is absent. Although one cannot but admire the adept rationalisation of McGhee and Clark, it is hard to conceive of a bridge as narrow, or one useable in fewer circumstances. The consequences of any shortfall in scientific or medical knowledge are, because of the hallowed legal doctrine of the burden of proof, visited in their full rigour against the plaintiff or pursuer. The effect of this is exactly as if either the

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[65]Per Lord Bridge, ibid. His Lordship goes on to approve in terms Sir Nicolas Browne-Wilkinson V.-C.'s analysis of the import of McGhee. See A. F. Phillips, op. cit.

[66]Which possibility, in cases of suitable evidence, does not appear to be closed off by Wilsher. Again, see A. F. Phillips, op. cit.

plaintiff's evidence was rejected on credibility, or his opponent's evidence was preferred for other reasons. In a legal system which is arguably the pride of Western democratic intellectual thought, it seems discordant to equate the conclusions of agnosticism with atheism.

It is submitted that these have posed perhaps the greatest challenge to rational legal analysis. It will be shown that the law has already made a major concession in its strict causal principles by allowing a material contribution or material increase in risk to suffice.

Vyner v. Waldenburg Bros.[67] perhaps started the process. The plaintiff was able to establish breach of statutory duty on the part of the defendants, and of course his own injury. However, the type of injury was a possible result of the defendant's breach, but was not proved as such. Nevertheless, this was held sufficient to transfer the burden of proof to the defendant, to show that the neglected precaution would not have averted the injury.[68]

The Vyner approach lasted until 1956, when overtaken by Wardlaw v. Bonnington Castings Ltd.[69]

In Bonnington, the plaintiff was employed by the defendants. He inhaled microscopic particles of silica whilst at work. These came from two different sources, one

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[67][1946] K.B. 50

[68]Cf. the modern example of McWilliams v. Sir William Arrol & Co. Ltd. [1962] 1 W.L.R. 295, a common law case of negligence in which it was inferred that, had the safety precaution (belt) been available, the deceased would not have worn it. This is an example of considering hypothetical past conduct, and also illustrates the "but for" test.

[69][1956] A.C. 613.

of which was "innocent"; the other was associated with a breach of statutory duty. Both sets of particles were inhaled simultaneously and not sequentially. The plaintiff subsequently contracted pneumoconiosis, and sued for damages in respect of the breach. It became clear that the onus of proof in respect of causation was to remain upon the plaintiff, unless there was specific statutory warrant for departing from this. This left the House of Lords little room for manoeuvre if they were to find for the plaintiff, and the burden of proof was effectively the same as it would have been in an equivalent common law reparation case. The crux of the matter was that the "guilty" dust alone could not have caused his pneumoconiosis. The plaintiff was therefore unable to lead evidence tending to show that the breach of duty only had, on the correct test of the balance of probabilities, caused his illness. It is submitted that today this would probably result in the onus not being satisfied and the case being dismissed.[70] Lord Reid resolved it thus:

> "[T]he disease is caused by the whole of the noxious material inhaled and, if that material comes from two sources, it cannot be wholly attributed to material from one source or the other...and the real question is whether the dust from the swing grinders [the "guilty" source] materially contributed to the disease...
> "A contribution which comes within the exception de minimis non curat lex is not material, but I

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[70]Although, of course, evidential inferences may be drawn in suitable cases, for example Gardiner v. Motherwell Machinery Co. [1961] 1 W.L.R. 1424.

> think that any contribution which does not fall within that exception must be material."[71]

It is submitted that the acceptance of a "material contribution" represents a significant reduction in the strictness of the standard for the plaintiff. Prior to Wardlaw, and on the unrelaxed civil standard of proof, the breach would have had wholly to have caused the harm. But, as we have seen, causation of the harm could wholly be attributed neither to the "innocent" nor to the "guilty" dust. It was impossible to state that the "innocent" dust would not have caused the harm but for the "guilty"; equally, the "innocent" component could not be exonerated either. Contrast this with the "normal" case in which it must be shown 51% (or more) likely that cause A produced effect B. Had all the silica dust been produced by a "guilty" method, the plaintiff would then have had to prove it at least 51% likely that this was the cause of the harm. This likelihood would then be accepted by the court as a certainty for legal purposes. Two propositions may therefore be distinguished; it is important to note that they are separate. The first relates to the degree of likelihood of the event's occurrence. This is the "balance of probabilities". It represents the minimum degree of probability beyond which the event or causal connection

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[71] Ibid., at p. 621. The emphasis is added. Consideration was of course given to statutory interpretation, although this need not detain us: see Lord Reid's opinion, ibid. at pp. 619-620. The case was followed in Nicholson v. Atlas Steel Foundry and Engineering Co. Ltd. [1957] 1 W.L.R. 613.

must be shown to be likely. The second proposition is the one which was changed in Wardlaw. Normally, the entire harm must be shown to be wholly caused by the breach. In Wardlaw, the major concession was that partial, rather than total, causation of the whole harm was accepted as sufficient. This, it is submitted, is a remarkable development. If no "discount", or causal apportionment, is given to reflect the uncertain degree of cumulative causal contribution of the "innocent" dust,[72] the effect is that an acknowledged partial cause is therefore deemed equivalent to a total cause.[73] The plaintiff's burden is being eased at the expense of rendering the defendant wholly liable for a partially[74] non-tortious injury.[75] Further, this "material contribution", which must by definition be less than half the cumulative total cause,[76] but more than "de

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[72]It is thought that this would be the rational solution. To the objection that the discount would be arbitrary in size, it could be replied that to do so is less unsatisfactory than to impute liability for the whole harm in the face of the limitations of knowledge.

[73]It should be noted that this partial causation must, of course, still be proved upon the balance of probabilities. The "partial" aspect of it refers to the causal contribution, and not to its establishment as proved to the satisfaction of the court.

[74]It may be potentially partial - or even total, but again there is no way of determining this.

[75]Cf. J. Stapleton, in Law, Causation and Common Sense, 1988 8 Oxford J. Legal Stud. 111 at p. 127.

[76]Otherwise the plaintiff could adopt a different approach and show that the breach had wholly and exclusively caused all the harm, on the balance of probabilities, i.e the simplest form of conventional causal enquiry.

minimis",[77] is ultimately treated as the whole cause.[78] To do this would only be just if the evidence could show, or support an inference, that the "guilty" dust was a sine qua non of the harm - which comes full circle to conventional "total" causation. Whilst it is conceivable that this might be desired, it is submitted that such an important question of policy should be fully and openly debated. In the absence of this, it is suggested that Wardlaw masked a fundamental change in the head of damage which is recoverable.

A subsequent common-law case in which this principle was considered and indeed extended by the House of Lords was McGhee v. National Coal Board.[79] As we have seen, McGhee was considered in Wilsher[80] to the effect that it simply represented a legitimate evidential inference and

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[77]Whatever proportion that represents; perhaps under 5%?

[78]Stapleton comments in relation to multiple possible causes (op. cit. at p. 43) that "[T]here is a problem,...,because the disease may have been triggered by conditions which are "innocent"....Here the plaintiff must show that it was exposure to the faulty conditions which was the more probable cause of triggering. So even in cases where the only possible source of this disease was under the defendant's control, the vagaries of the all-or-nothing balance of probability test...will still be involved."

[79]1973 S.L.T. 14; 1973 1 W.L.R. 1. See generally Charlesworth and Percy on Negligence, seventh edition, R. A. Percy, Sweet and Maxwell, 1983, at p. 316 et seq. Remarkably little is said about the case in Causation and the Law, op. cit., by Hart and Honore. See p. 410; it is merely summarised as an example of material contribution and not as material increase in risk.

[80]Per Lord Bridge in Wilsher, supra, at p. 569F - G.

not any new principle of law.[81] It is submitted that this is disingenuous.

The pursuer's employment entailed that he worked in very dusty conditions in the defenders' brickworks. He was unable to wash off the brick-dust with which he was thus coated during the working day, because of the defenders' negligent failure to provide showers or other suitable washing facilities. He then cycled home still caked in dust, and ultimately contracted dermatitis arising from the contact with it.

It is immediately evident that if the defenders' only breach of duty was in failing to provide showers or similar for use at the end of the working day, then the pursuer's exposure to the dust during the day was not delictual and could not therefore found any claim as such for damages, if the harm caused was solely attributable to the exposure during the hours of work. This of course suggests, correctly, that the central issue was the causal impact of the continuing dust which exerted its effect and became delictual after the end of the working day, potentiated by

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[81]Lord Wilberforce's expressions to the contrary (that some relaxation of the onus was allowable (1973 1 W.L.R. at p. 7)) were considered by Lord Bridge in Wilsher ([1988] 2 W.L.R. at p. 567) to be a minority view, unsupported by authority (particularly Wardlaw). This certainly appears to restrict the scope for relying upon or widening McGhee in future. It would be unlikely to expect Wardlaw to support such a relaxation, because the alternative relaxation devised to avoid the unpalatable consequences of precisely that onus was the "material contribution" formula instead of conventional total causation. This type of approach was later utilised in McGhee.

the pursuer's exertions on his bicycle.

At the outset, it may be remarked that some differences between this and Wardlaw do exist and indeed give some basis for arguing that McGhee is not a case involving cumulative multiple causes. Lord Bridge stated in Wilsher that,

> "[A] distinction is...apparent between the facts of Bonnington Castings Ltd...., where the "innocent" and "guilty" silica dust particles which together caused the pursuer's lung disease were inhaled concurrently and the facts of McGhee....where the "innocent" and "guilty" brick dust was present on the pursuer's body for consecutive periods. In the one case the concurrent inhalation of "innocent" and "guilty" dust must both have contributed to the cause of the disease. In the other case the consecutive periods when "innocent" and "guilty" brick dust was present on the pursuer's body may both have contributed to the cause of the disease or, theoretically at least, one or other may have been the sole cause."[82]

On the relevance of Wardlaw to McGhee, Stapleton has stated that,

> "[W]hat is remarkable is the misplaced reliance placed on the case by the House of Lords in McGhee..., a case not of multiple cumulative sources of damage but of multiple possible sources...
>
> "But the evidence was that the disease may have resulted from a "triggering" incident of exposure and there was no way of showing that it was more likely than not to have been triggered by the guilty source of risk. There was no way, therefore, for the pursuer to prove on the balance of probabilities that the guilty source had caused the damage - i.e. that is was a sine qua non of it - and therefore on the basis of

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[82]Per Lord Bridge in Wilsher, at p. 567C - D.

Bonnington Castings itself, he could not win."[83]

Some illumination upon this point may be obtained from the opinions in McGhee itself. Lord Reid said, reflecting generally their Lordships' views on how the matter was to be approached:

> "[T]he respondents seek to distinguish Wardlaw's case....by arguing that then it was proved that every particle of dust inhaled played its part in causing the onset of the disease, whereas in this case it is not proved that every minor abrasion played its part...
>
> "In the present case the evidence does not show - perhaps no one knows - just how dermatitis of this type begins. [His Lordship then expounded possible causal pathways which we need not consider in detail.]
>
> "But I think that in cases like this we must take a broader view of causation. The medical evidence is to the effect that the fact that the man had to cycle home caked with grime and sweat added materially to the risk that this disease might develop. It does not and could not explain just why that is so. But experience shows that it is so. Plainly that must be because what happens while the man remains unwashed can have a causative effect, though just how the cause operates is uncertain.
>
> "There may be some logical ground for such a distinction where our knowledge of all the material factors is complete. But it has often been said that the legal concept of causation is not based on logic or philosophy. It is based on the practical way in which the ordinary man's mind works in the every-day affairs of life."[84]

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[83]J. Stapleton: Law, Causation and Common Sense, op. cit. at p. 127. The footnotes are omitted and the emphasis is added.

[84]Opinion of Lord Reid, Wilsher, 1973 S.L.T.(Reports) at p. 22. Their Lordships appeared to consider the matter one of cumulative causation and that consecutive or simultaneous exposure to the causal agent was immaterial. See the opinions of Lord Simon of Glaisdale and Lord Salmon. At p. 27 (ibid.) the latter states strongly that causal enquiry should not become too recondite a field.

The view of the House of Lords gives at best equivocal support for the theory of "mutual exclusivity", although it cannot be ruled out. It is submitted that their Lordships dealt with the case as one of cumulative causation, and that it may be considered as an authority in that context. It is further suggested that although reliance was placed upon Wardlaw, McGhee itself dealt with the issue in a different manner - that of material increase in risk,[85] and to that extent McGhee did extend the previous law. It is proposed therefore to consider the case as one of cumulative causation.

The starting point in their Lordships' analysis was that a material contribution, i.e. partial causation, of the result would suffice.[86] If a defender had produced one of two causes, for example, that would be sufficient. It is here that the idiosyncracies in the evidence and terminology emerge. Because of the incomplete medical knowledge of the aetiology of the condition, at first instance Dr Hannay's "..evidence was that he could not say that the provision of showers would probably have prevented the disease. He said that it would have reduced the risk materially but he would not go further than that."[87] Another expert, Dr Ferguson, said "..that washing reduces

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[85]Discussed infra.

[86]McGhee, 1973 S.L.T. per Lord Reid at p. 21.

[87]Opinion of the Lord Ordinary (Kissen), summarising the evidence led at first instance, 1973 S.L.T. at p. 17.

the risk."[88] The Lord Ordinary held that the distinction drawn by Dr Hannay, to the effect that an increase in risk did not necessarily equate to a material contribution. He continued:

> "[A] material increase in risk may refer only to possibilities and may not make a possibility into a probability. It may strengthen the possibility but that cannot mean that in all such cases the possibility has become a probability. What the pursuer has to show is that, as he avers, he would not have contracted the disease but for the defenders' breach of duty. He has to show that this was probable and the degrees of risk have no relevance unless they make a contraction of the disease more probable than not contracting the disease."[89]

It is this terminology, the ultimate product of scientific caution based upon incomplete medical knowledge, which, it is submitted, accounts for the difference in expression of the Wardlaw test in this case. It is submitted that the explanation of the equiparation of the two formulae by the House of Lords (i.e. material increase in risk and material contribution) may be as follows.[90]

Before the pursuer contracted dermatitis, the dust constituted a risk, and as with other "risk factors", it could have been identified or described as such. In this case such factors were only the "guilty" and "innocent"

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[88]Opinion of the Lord Ordinary (Kissen), summarising the evidence led at first instance, ibid., at p. 17.

[89]Opinion of the Lord Ordinary (Kissen), 1973 S.L.T. at p. 17.

[90]To the limited extent that this is inconsistent with the reasoning of the Lord Ordinary, it is with the greatest respect submitted that that presently expressed is the better view.

dust particles. After the point at which these risks materialised and the disease supervened, the language of risk therefore became inappropriate. For example, when one has tossed a coin in order to discover which way up it lands, a statement referring to risk evaluates only the chances before the event. Once the event occurs, a fundamental change has taken place in that the tangible event must have been caused by something. After the occurrence, on the limited information available all that could be done was to translate the language of risk directly into causal terms explaining the actual occurrence.[91] It is submitted that this was the correct approach, given the evidence, the wording of the Lord Ordinary's judgment and the law.[92] It is unfortunate that, in the absence of analysis of the provenance of the "risk" expression, there came to be an over-emphasis upon language perhaps at the expense of the underlying concepts. Thus it was in Wilsher that McGhee came to be used, and perhaps understood, as eroding the substantive law further than Wardlaw. However, their Lordships were aware of the policy-based nature of McGhee and its consequences. These factors have been summed up by Stapleton, who considers that this decision

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[91]See the discussion in, A Note on Causation, W.A. Wilson, supra.

[92]Indeed, Lord Reid states that the distinction may be appropriate in cases wherein more is known of the aetiology of the condition (1973 S.L.T. at p. 22).

> "..constitutes a remarkable rejection of the traditional preponderance of probabilities concept as inadequate when dealing with the classic multiple causation problem in disease[93] cases: proving that a negligent omission was the medical cause of the disease where estimates of relative risks are unavailable...where other possible sources of risk are outside the defendant's control, considerations of deterrence and fairness to the defendant arise more strongly. This is where the reasoning in McGhee is inadequate. In economic deterrence terms the Lords' "solution" to the victim's causation dilemma overinternalizes losses to the defendant to an even greater degree than the traditional regime of an all-or-nothing balance of probability test....There is little, if anything, in the McGhee reasoning to prevent it being used by a person who can show that his unreasonably (that is, negligently) stressful work conditions materially increased his risk of heart attack or disease."[94]

The aspects of Wilsher of relevance to this discussion have already been considered, and it is mentioned here only in order to recap, briefly, upon its guidance on the case of McGhee. This, it is submitted, should be accepted as having authoritative implications as to future decisions upon medical causation.[95] The case may be regarded as one of evidential inference. If so, a decision on this basis must be perceived as closely associated with its particular

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[93]And, it is submitted, other cases in which similar difficulties may arise - such as those of medical negligence.

[94]J. Stapleton, Disease and the Compensation Debate, op. cit., at pp. 46-47. Footnotes omitted.

[95]It is illuminating that the Vice-Chancellor (Sir Nicolas Browne-Wilkinson) commented on McGhee that "..Lord Reid and Lord Wilberforce..accepted that the decision was based not on logic but on common sense or public policy. The difficulty is to know whether...it is right to extend further an illogical decision taken on grounds of policy to cover the present case.." (Wilsher, [1986] 3 All E.R. at p. 835c).

facts and not therefore likely to be developed or propagated.[96] This is sufficiently important as to warrant emphasis:

> "[T]he conclusion I draw...is that McGhee...laid down no new principle of law whatever...
>
> "On the contrary, it affirmed the principle that the onus of proving causation lies on the pursuer or plaintiff. Adopting a robust and pragmatic approach to the undisputed primary facts of the case, the majority concluded that it was a legitimate inference of fact that the defenders' negligence had materially contributed to the pursuer's injury. The decision, in my opinion, is of no greater significance than that and to attempt to extract from it some esoteric principle which in some way modifies, as a matter of law, the nature of the burden of proof of causation which a pursuer or plaintiff must discharge once he has established a relevant breach of duty is a fruitless one."[97]

This is a further clear signal that the existing causal principles are to be applied strictly. In effect, it retains the Wardlaw concession as to material contribution, but no more. In general, it is therefore consistent with the other recent cases which we have considered. It is also open to the same criticism that the consequences of lack of scientific knowledge are visited upon the pursuer, as a result of the onus of proof. It may be observed that an ideal solution would be to visit these consequences

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[96]This approach is confirmed by Rhesa Shipping Co. S.A. v. Edmunds and Another, The Popi M [1985] 2 All E.R. 712 in the context of satisfying the burden of proof where two separate and highly unlikely causal possibilities, neither of which could be substantiated, existed.

[97]Per Lord Bridge, at p. 569F et seq., ibid.. His Lordship's opinion was agreed unanimously by the House of Lords. See also A. F. Phillips, op. cit..

equally - perhaps upon neither. Before considering this, we may consider the case of Hotson v. East Berkshire Area Health Authority.[98] It may be considered both as exemplifying the strict approach to causation which we have hitherto considered, but also as purveying an inflexible and mechanistic reaction to an important question of only slightly greater sophistication than those considered supra.

Hotson v. East Berkshire Area Health Authority

The plaintiff in this case, aged 13, fell from a rope several feet to the ground, suffering a fracture of his left femoral epiphysis. He was thereafter examined by a hospital's casualty unit medical staff, who failed to diagnose this injury. After five days of pain at home, he was again taken to hospital, x-rayed, and the correct diagnosis was made. The appropriate treatment, an operation to free the damaged joint and to insert a metal pin into it, was performed. Unfortunately, avascular necrosis of the epiphysis set in. As its name implies, this is effectively the "death" of the circulation of the blood supply to the area. Hence, the availability of oxygen and all the other support processes required for the

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[98]At first instance, this is reported at [1985] 3 All E.R. 167 (Hotson v. Fitzgerald, Simon Brown J.); in the Court of Appeal at [1987] 1 All E.R. 210 and finally, in the House of Lords, at [1987] 2 All E.R. 909.

joint ceased. Serious disability, and early onset of osteo-arthritis, resulted from this. The dispute centred around the consequences of this failure to diagnose the condition on the plaintiff's first admission to hospital. It was admitted that this had been negligent. Simon Brown J.'s salient findings were as follows.

> "Even had the defendants correctly diagnosed and treated the plaintiff...[on his initial admission]...there is a high probability, which I assess as a 75% risk, that the plaintiff's injury would have followed the same course as it in fact has, ie he would have developed avascular necrosis of the whole femoral head with all the same adverse consequences as have already ensued and with all the same adverse future prospects....
>
> "That 75% risk was translated by the defendants' admitted breach of duty into inevitability. Putting it the other way, the defendants' delay in diagnosis denied the plaintiff the 25% chance that, given immediate treatment, avascular necrosis would not have developed...
>
> "Had [it] not developed, the plaintiff would have made a very nearly full recovery...The reason why the delay sealed the plaintiff's fate was because it followed the pressure caused by haemarthrosis (the bleeding of ruptured blood vessels into the joint) to compress and thus block the intact but distorted remaining vessels with the result that even had the fall left intact sufficient vessels to keep the epiphysis alive (which, as finding no. 1 makes plain, I think possible but improbable) such vessels would have become occluded and ineffective for this purpose."[99]

It was held at first instance that the plaintiff had been wrongfully denied a 25% chance of recovery. The proportion of a quarter of the full amount of damages in respect of the avascular necrosis was then awarded. This figure meant,

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[99]Per Simon Brown J., ibid., at p. 171.

in effect, that the health authority was responsible for causing a quarter of the plaitiff's disability, instead of viewing the 25% and 75% chances respectively as mutually exclusive single causes, the materialisation of either of which would have caused the whole condition. It should perhaps also be noted that this was not just a question of analysing an increase or decrease in risk of a certain percentage. The chance of recovery also declined to zero - in other words then rendering the outcome statistically certain. The question in issue was in fact either one of causation or alternatively one of the classification and quantification of damages. The award of damages was approved by the Court of Appeal, but the House of Lords unanimously allowed the further appeal, reversing the court below.[100] Essentially, their Lordships' decision was that the harm was the avascular necrosis and not the plaintiff's ingenious formulation of the loss of the chance of recovery.[101] This being so, it was then unnecessary to consider whether or not such a loss could sound in damages.[102] The remarks concerning this possibility were of

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[100]Cf. Chaplin v. Hicks [1911] 2 K.B. 786.

[101]By analogy with authorities elsewhere, for example in actions for loss of a chance based ultimately upon contract. See Kitchen v. Royal Air Forces Association [1958] 1 W.L.R. 563; cf. Kenyon v. Bell 1953 S.C. 125.

[102]In Takaro Properties v. Rowling [1988] 2 W.L.R. 418 (Privy Council) the causal issue of whether an unprofitable company might ever have become profitable was undecided, as no negligence was held to have taken place.

course obiter, but Lord MacKay was the least discouraging on the point.[103] Given that the harm was to be considered as the condition itself, it was clear that the plaintiff was unable to surmount the hurdle of proof of causation upon the balance of probabilities. To do so, he would have had to show that the risk attributable to the negligence was the one which actually materialised, proved likely to a level of 51% probability or more. The findings in fact could not support this.[104] It might be argued that Wardlaw-type reasoning would help the plaintiff at this point, leaving aside the (in effect) weakened case of McGhee. Such an argument would state that in Wardlaw a contribution greater than de minimis but less than the required 51% was a sufficient causal component as to infer liability. Indeed, such a proportion might well encompass the present figure of 25%. The reason why this type of argument would not work in Hotson was simply because the starting point for enquiry, unfortunately for the plaintiff, was a 75%

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[103]"I consider that it would be unwise...to lay it down...that a plaintiff could never succeed by proving loss of a chance in a medical negligence case." Per Lord MacKay, [1987] 2 All E.R. at p. 916d.

[104]Compare Mitchell v. Hounslow and Spelthorne Health Authority 1984 The Lancet 579, in which a 60% chance of avoiding the harm (brain damage (subsequent to deprivation of a child's oxygen through the umbilical cord because of negligent compression of it by a nurse)) had there been no negligence was held sufficient to establish causation. This was presumably on the basis that the damage was 60% likely as a result of the negligence, thus avoiding the potential post hoc ergo propter hoc fallacy.

chance of developing the disputed condition.[105] With only the avascular necrosis classified as the loss, application of the standard balance of probabilities test thus yielded the clear result that the plaintiff was to be held, in law, the sole author of his misfortune. We may conclude from this that causation is to be considered not merely strictly, but also narrowly and very much as an "all or nothing"[106] test. In addition to its actual ratio, then, the case heralds an even greater restriction of what is arguably already a difficult rule for a plaintiff or pursuer to satisfy.[107] Hotson occasioned much debate.[108] Stapleton has argued that the loss was correctly characterised as loss of a chance of recovery, which could

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[105]Lord MacKay's statement (Hotson, [1987] 2 W.L.R. at p. 915g et seq.) to the effect that it was not correct to say the plaintiff had a 25% chance of recovery on initial arrival at the hospital is doubted. As his opinion makes clear, whatever the reality of the situation the information directly relevant to determining this was unavailable and the basis adopted by Simon Brown J. appeared to be a reasonable one in the circumstances.

[106]See Proof of Causation in Medical Negligence Cases, J. G. Logie, op. cit., at p. 28 et seq., including the analysis of the "all or nothing" nature and Lord Reid's speech on the burden of proof in Davies v. Taylor [1974] A.C. 207.

[107]See, A Lost Chance for Compensation in the Tort of Negligence by the House of Lords, T. Hill, 1991 54 M.L.R. 511; cf. paper by Dr W. Scott contrasting this with a medical and scientific approach to causation (personal communication).

[108]For example, The Gist of Negligence, J. Stapleton, (1988) 104 L.Q.R. 386; Law, Causation and Common Sense, J. Stapleton, op. cit.; Proof of Causation in Medical Negligence Cases, J. G. Logie, op. cit.; Further Reflections on Medical Causation, A. F. Phillips, op. cit.; Causation - The Lords' Lost Chance?, D. Price, (1989) 38 I.C.L.Q. 735; Damages for Loss of a Chance in Tort?, F. Cownie 1989 5 P.N. 194 and Causation and the Increase of Risk, A. Boon (1988) 51 M.L.R. 508.

be established on the balance of probabilities. Their Lordships therefore applied their minds to the wrong test, as the quantification of damages could not be raised prior to proof of causation. She also argues that the formulation of the claim defines the subsequent causal enquiry, and that the former issue was not considered at all.[109] Acceptance of loss of chance as a head of damage is further argued to give a more coherent connection with the wrong, thus reducing the scope for duties effectively unenforceable because of causal idiosyncracies.[110] In the context of tort generally, it has been argued persuasively and strongly that the law should admit of reparation for wrongful loss of a chance and that the system of negligence perhaps pre-disposes to an unfortunate melding of the concepts of valuation and causation.[111] There seems no reason why this should not apply to cases of medical negligence in delict,[112] particularly when the law of

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[109]J. Stapleton, The Gist of Negligence, op. cit., at pp. 392-393. Cf. D. Price, The Lords' Lost Chance, op. cit., at pp. 746 et seq.

[110]See, J. Stapleton, The Gist of Negligence, op. cit.; ibid. and p. 394 et seq. Cf. Cook v. Lewis [1952] D.L.R. 1 (S.C.C.), in which two persons negligently discharged guns in the plaintiff's direction. It was impossible to decide whose bullet had struck him. Both, according to the Supreme Court, could be held liable.

[111]See, for example, Causation, Valuation, and Chance in Personal Injury Torts Involving Preexisting Conditions and Future Consequences, J. King, 1980/81 90 Yale L. J. 1353, especially Part II, at p. 1363 et seq.

[112]See Kyle v. P. & J. Stormonth Darling, W.S., 1992 S.L.T. 264 (O.H.), in which a client averred loss of a reasonable prospect of success in an appeal which his solicitors had

contract already admits of characterisation, and recovery in respect of, such loss.

The "all or nothing" (or " "yes or no" "[113]) nature of the test for causation has also been subjected to trenchant criticism,[114] principally because its mechanistic and inflexible nature tends to under- or over-compensate. Therefore, arguably, it provides an inflexible and unfair means of distinguishing between meritorious and non-

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conducted negligently. Loss of this legal right (i.e. to continue his appeal) was held to be a wrong capable of independent valuation; proof before answer was allowed. See Lord Prosser's opinion in Kyle, ibid., at p. 266K et seq. Arguably, the Hotson-type situation is sufficiently analogous as to suggest a similar outcome.

[113]D. Gerecke, Risk Exposure as Injury: Alleviating the Injustice of Tort Causation Rules, 1990 35 McGill L. J. 797 at p. 802.

[114]See the discussion in Proof of Causation in Medical Negligence Cases, J. Logie, op. cit. at p. 28 et seq., and J. King, Causation, Valuation, and Chance in Personal Injury Torts Involving Preexisting Conditions and Future Consequences, ibid.

meritorious claims;[115] nor is it able to cope rationally with scientific uncertainty. It is also unfortunate that, in cases of loss of chance, much now turns upon whether a plaintiff can formulate his claim in contract or not.[116] It has been commented that "..McGhee[117] was in its modest way a useful decision, showing a welcome flexibility with respect to entrenched doctrine. One can only hope that the decision....was a harbinger of things to come and not an evanescent incident."[118] Ultimately, it seems that the flickering recognition in McGhee of the difficulties posed by the limitations of scientific knowledge has now gone.

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[115]J. Logie quotes (ibid., at p. 29) Lord Reid's rejection of the balance of probabilities test in Davies v. Taylor [1974] A.C. 207 at p. 213 [the case involved a claim by a widow in respect of her husband's death; she had left him five weeks prior to the accident]: "[I] can see no ground at all for saying that the 40 per cent case fails altogether but the 60 per cent case gets 100% [damages]. But it would be almost absurd to say that the 40% case gets nothing while the 60 per cent award is scaled down to that proportion of what the award would have been..." ". Cf. Hotson, [1987] 2 All E.R. at p. 915j - 916a, where Lord MacKay of Clashfern quotes the principle enunciated by Lord Diplock in Mallett v. McMonagle [1970] A.C. 166, at p. 176: " "[I]n determining what did happen in the past a court decides on the balance of probabilities. Anything that is more probable than not it treats as certain." ". See also E. J. Weinrib, A Step Forward in Factual Causation, op. cit., at p. 523 et seq., considering McGhee and its implications. J. Stapleton, in Disease and the Compensation Debate, op. cit., also gives a full account of the test, at p. 38 et seq.

[116]This and other aspects are considered in Chance and the Burden of Proof in Contract and Tort, B. Coote, 1988 62 A.L.J. 761 at p. 770 et seq.

[117]And also Clark v. McLennan, supra (see A. F. Phillips, op. cit.), in the writer's submission.

[118]A Step Forward in Factual Causation, E.J. Weinrib, op. cit., at p. 534.

The cases in each of these categories demonstrate a consistent theme, that the traditional burden of proof upon the pursuer or plaintiff is not to be relaxed. Where the direct connection cannot be demonstrated as such, the inference of causation may only be drawn where the evidence is strong enough to permit this upon the balance of probabilities. Neither the substantive nor procedural law may be changed in order to ease this task. The result may be to deny a pursuer a remedy, to deem certain duties unenforceable or to make a decision which does not correspond with scientific knowledge. Such a rule has been legally unexceptionable for many years. Various reasons may, speculatively, be advanced for this. Those which commend themselves to the writer are that the expectations of the public have been increased (perhaps beyond the ability of medicine to achieve, on occasion), and the increasing technology applied in medicine. When tragedies occur, more technical medicine may have the effect of rendering adverse consequences more severe, particularly where neonates or children are involved.

It is submitted that the cases which have occasioned the greatest difficulty are likely to be those in which the causal issues occupy a penumbra of incomplete scientific knowledge. In Wilsher, if it had been possible to

determine which of the five possible causes had materialised, or the exact causal efficacy of the "innocent" and "guilty" dust in Wardlaw or McGhee, cases involving many years' stress and expense for both sides would not have been required.[119] That of Wilsher ultimately required re-trial on the causal issue. Kay and Hotson do not fit this pattern, although they may be criticised upon other grounds. The former, conventionally analysed, is simply a case in which there was negligible evidence in support of the pursuer's case even though the facts may perhaps appear upon first blush to approach res ipsa loquitur. Nevertheless, it is suggested that the adversarial philosophy perhaps made the original claim and appeals more likely. Tactical considerations on the part of the defenders, such as their better knowledge of the causal issue and of the difficulties in discharging the burden of proof,[120] are likely to have militated against the pursuer's settlement of the case. In any event, although it could not be established legally, in the writer's understanding it is not certain that the deafness could not be said to have been caused by the overdose. It is therefore at least possible that the harm could have been

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[119]See also Thompson v. Smiths Ship-repairers (North Shields) Ltd. [1984] 1 All E.R. 881, a case involving industrial deafness through exposure to high noise levels.

[120]See The Civil Standard of Proof, R. Eggleston, ch. 10 in Evidence, Proof and Probability, second edition, 1983, Weidenfeld and Nicolson.

delictually caused.[121] Hotson may be criticised on the grounds that the classification of the issue by the House of Lords was erroneous, and that its result may give rise to unenforceable duties, as indeed may other cases arising in medical causation. If, as is suggested, these decisions are referable to the existence of a "gap" between scientific knowledge and that which is partially, or not known, the difficulties are likely to be perpetuated. This is because even as new knowledge is discovered, the boundaries of what is not understood will also recede - leaving the "gap" intact. The judicial attempts, in recognising this burden, to reduce it[122] have been notably short-lived. A doctor has commented upon the existing approach that,

> "[T]he "all or none" approach is reasonably fair to patients who, statistically, would have had chances somewhere near 0% or 100% of the predicted outcome, but tends to be unfair to those patients whose statistical chances were nearer the 50% borderline..."[123]

Many of the difficulties identified by Stapleton in relation to man-made disease[124] may also bedevil causal

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[121]The writer is aware of the nature of the evidence led and the unlikeliness of sustaining such an argument, bolstered by Rhesa Shipping Co. S.A. v. Edmunds and Another, The Popi M, [1985] 2 All E.R. 712.

[122]Lord Davidson in the Outer House in Kay (supra), Clark v. McLennan(supra) and Hotson (supra, apart from the House of Lords) serve to illustrate this.

[123]Dr W. Scott, personal communication, 2 March 1992.

[124]J. Stapleton, Disease and the Compensation Debate, op. cit., at p. 33 et seq.

enquiry in medical negligence cases. These include symptoms which are too difficult to detect or to associate with negligence, or where a very long time-lapse, perhaps even a generation, exists between the biological expression of the harm and the negligent episode. These may be added to the difficulties of multiple causation and the onus of proof which have already been considered.[125]

Conclusion

What lessons or conclusions, if any, may be drawn from the foregoing? It is submitted that the so-called "simple causation" examples may in fact be regarded as a variant on the theme of multiple mutually exclusive causes. In these, background risk is the corollary of the pursuer's inability to prove causation by the allegedly delictual source.

A traditional justification advanced for the existence of causal enquiry in cases of negligence is that it enforces responsibility for one's own actions.[126] Some of the underlying reasoning is that normally there is a close connection between a person's actions and their result, be

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[125]In relation to the last-mentioned of these, readers are referred to the detailed consideration and criticism of this in Stapleton, op. cit. at p. 38 et seq.

[126]McBryde does not mention this specifically: The Advantages of Fault, 1975 J.R. 32, although it may well be subsumed under "[M]orality", at p.40 et seq. The concepts of voluntariness and responsibility are discussed in Voluntary Acts and Responsible Agents, B. Williams, 1990 10 Oxford J. Legal Stud. 1.

it harmful or otherwise. This is held to be a matter of common-sense; thus, pushing a cup over the edge of a table causes it to fall and probably to break, depending upon the nature of the surface upon which it lands.

The next component is that those who act are considered both to be aware of the results, as in the example of the cup, and also to have intended those results.[127] If, on this view, we wish as a matter of policy to hold people generally responsible for their own actions,[128] then in any practical enquiry causation must figure strongly.

Against this must be considered the view expressed by critics[129] such as Ison, sufficiently exasperated by analysis of causal issues as to comment that

> "[I]n practice, the difficulties of adhering to any coherent rules for establishing causation are insoluble, and the truth of the matter is that purely intuitive moral judgments play a crucial

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[127]This argument, admittedly an extreme one, is advanced by R. A. Epstein in support of his equiparation of causation and legal liability without the notion of fault (see A Theory of Strict Liability, 1973 2 (University of Chicago) Journal of Legal Studies 151 at p. 168 et seq. Such an analysis is open to various objections, but it is submitted that the reasoning underpinning it is present, in much less extreme form, in the current tort and delict system of liability for negligence.

[128]And not succumb wholly to the doctrines of Freud!

[129]See also Atiyah's Accidents, Compensation and the Law, op. cit., especially chapter 4, Causation and Remoteness of Damage, and Medical Negligence - The Burden of Proof, M. A. Jones, 1984 (6 January) N.L.J. 7.

role."[130]

Following analysis, Stapleton concludes that

> "..the approach of the Law Lords in McGhee to the typical multiple possible causation problem in a disease case shows how extreme the departures from conventional theory must be before any attempt can be made to accommodate these cases. The result is the creation of anomalies and a distortion of legal rules which, in any case, ultimately seems to prove a dead end....
>
> "A final implication from...[McGhee][is]...the Law Lords, faced with the typical causation barrier to disease compensation, abandoning a traditional element of the one-to-one corrective justice model, namely that the defendant be proved to be more probably than not the party who caused the plaintiff's damage, and allowing recovery against a defendant who had merely been shown to have negligently added one of a number of possible sources of risk.[131] If this is the best solution to the problem which the common law can provide, it suggests that an accommodation of disease issues would weaken the traditional basis of tort liability. As Calabresi has noted, once it is accepted that justice does not require an individual wrongdoer to compensate his actual victim it becomes more difficult to support the fault system in terms of justice...."[132]

It may be noted that since the publication in 1986 of Stapleton's book, Disease and the Compensation Debate, from which this passage is quoted, the law on multiple causes

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[130]The Forensic Lottery, T. Ison, Staples Press, London, 1967, ch. 2 (section 5: causation), at p. 18. (This refers to the Hart and Honore analysis of causation in common-sense terms.)

[131]The present writer submits that any reversal of the onus of proof in respect of causation would have the same effect and be subject to the same criticism.

[132]J. Stapleton, Disease and the Compensation Debate, op. cit., at p. 49. Footnote omitted. In Calabresian terms, McGhee over-internalises liability, and Hotson and Wilsher would over-externalise it. See, The Costs of Accidents, G. Calabresi, New Haven/Yale U.P., 1970, chapters 7 and 8. Cf. Accidents, Costs and Legal Responsibility, S. Stoljar, 1973 36 M.L.R. 233.

generally has been clarified, albeit that its "all or nothing" nature remains unrelaxed.[133] Although McGhee was not overruled, as we have seen it was effectively confined to its own factual circumstances. Thus a pursuer or plaintiff will have to support the drawing of any favourable inference as to causation with strong evidence. It therefore appears that there are two equally unpalatable alternatives, depending upon whether McGhee is regarded as likely to be decided the same way should the occasion arise. The first is Stapleton's view that the logic behind the policy-based decision in McGhee undermines the rationale of the negligence system, and that no other solution has yet been proffered by the common law of negligence. Indeed, the decision may be argued to be one of distributive rather than corrective justice.[134] The second is that the law subsequently appears to be set upon a course in which there is little or no relaxation of the requirements of proof of causation. Whilst this might at least reflect traditional tort preoccupations consistently, it must also be judged unsatisfactory because the pursuer might be refused a just remedy.[135] Although Stapleton's central concept of man-made disease is unlikely to arise in

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[133]Chance and the Burden of Proof in Contract and Tort, B. Coote, 1988 62 Austr. L. J. 761.

[134]J. Stapleton, Disease and the Compensation Debate, op. cit. at p. 49.

[135]It is thought that the law is equally unsatisfactory if it works injustice either to pursuer or defender.

medical negligence, it is thought that many similar difficulties do exist; after all, both areas are concerned with questions of medical causation. Indeed, there may be even greater difficulties in respect of this type of case. These may take various forms, not the least being the average person's lack of knowledge of medical science and practice, or a reluctance of medical witnesses to condemn their fellow professionals.[136] Distinguishing the negligently-caused exacerbation of a disease from its pre-existing state, and the detection of some of the sequelae of negligent clinical interaction, are further difficulties of similar form as those identified by Stapleton in relation to man-made disease, but arising in the context of medical negligence. As Gerecke has commented, "[T]he flaws of the all or nothing approach are exposed in the increased risk cases. In practical terms, the approach's most glaring weakness is its denial of recovery to almost all increased risk plaintiffs."[137] Further, it has been coherently and strongly argued that the causal element in

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[136]Some of these risk factors and difficulties are discussed in a practical context by J. Phillips and K. Hawkins, in Some Economic Aspects of the Settlement Process: A Study of Personal Injury Claims, 1976 39 M.L.R. 497.

[137]D. Gerecke, Risk Exposure as Injury: Alleviating the Injustice of Tort Causation Rules, 1990 35 McGill L. J. 797 at p. 803.

the ascription of liability may not be the best way to achieve the responsibility element in the law.[138]

However, it is sufficient to fulfil the purpose of this chapter to submit that McGhee, Wilsher and Hotson demonstrate the difficulty inherent in the common law of medical negligence to provide a satisfactory answer to causation questions, both those actually encountered and those likely to be encountered in future.[139] For clarity, however, it is worth placing this conclusion in slightly broader perspective.

If, as seems likely, this disparity between scientific or medical and legal causation cannot satisfactorily be bridged, then we must take into account the aims of the law at a more fundamental level. A main justification for causal enquiry is the ascription and enforcement of responsibility.[140] If this is accepted as a satisfactory working aim, and further that the McGhee debate shows that conventional one-to-one corrective justice cannot accommodate this, we must look beyond the narrow confines

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[138]L. Alexander, Causation and Corrective Justice: Does Tort Law Make Sense? 1987 6 Law and Philosophy 1. See also J. Coleman, Moral Theories of Torts, Part I, 1982 1 Law and Philosophy 371, e.g. at p. 378 et seq.; cf. E. Weinrib, Toward a Moral Theory of Negligence Law, 1983 2 Law and Philosophy 37, at p. 47 et seq.

[139]See, Radiation: Proving the Causal Link with Cancer, D. Brahams, 1988 (August 12) N.L.J. 570.

[140]This is only considered in the context of medical negligence and not in the full scope of tort law, which is outwith the present work.

of the present authorities.[141] Possible avenues include the following.

(1) Reversal of the onus of proof.[142] It is thought that this would be open to similar objections as McGhee.

(2) No-fault or other compensation schemes. The former are generically open to the argument that only the fault criterion is eliminated, the troublesome causal element being perpetuated. However, to some degree such objections may be countered by providing a "schedule" of conditions within the scope of the scheme,[143] i.e. a partial removal of this element. Unfortunately, it is likely that the variety of conditions and consequences to be expected in any such reform of the law of medical negligence would render this impracticable. This is discussed infra in the context of reform.

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[141]See A Step Forward in Factual Causation, E.J. Weinrib, cit. sup. at p. 533-534.

[142]For example Cook v. Lewis [1952] 1 D.L.R. 1.

[143]Discussed by J. Stapleton, Disease and the Compensation Debate, op. cit., at p.49 et seq.

(3) Causation and the "enforcement of responsibility" aim might both be retained in a modified form, with liability allocated or discounted according to causal responsibility. An example of this type of approach is in the American so-called "market share" doctrine.[144] This has some attractions, but loses its gloss somewhat on closer examination. It has been principally applied in the U.S in product liability cases; such cases may be peculiarly appropriate for this theory. There will be a finite number of manufacturers, each of whom will have kept records of the numbers and date of production of the drug involved. Extensive data will already be available from clinical trials as to dose-response effects and this will probably ease the subsequent aetiological enquiry even where unforeseen consequences result. Many epidemiological studies are done before the launch of a new drug; data are therefore more readily and generally available.[145] In medical

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[144]A recent and compendious paper which explains fully, and strongly advocates, this theory is: Risk Exposure as Injury: Alleviating the Injustice of Tort Causation Rules, D. Gerecke, cit. sup. See generally also, Developments in Victim Compensation: A Look beyond the Superfund Act of 1980, anon., 1985 10 Columbia J. Environmental L. 271.

[145]The new product liability regime in the E.C. is based upon strict liability. See Product Liability, A.M. Clark, Sweet and Maxwell, 1989. Vaccine damage has again been a matter of concern: see "[W]hooping cough vaccine on trial again", C. Dyer,

negligence cases, vastly varied individuals, physiological processes, diseases and sequelae are involved. Little of the aetiology of any one condition may be known even for the general population, and this may be compounded by the idiosyncracies of the individual negligently treated patient. As has been pointed out, again by Stapleton, it is particularly in cases in which some discount for causal non-responsibility is needed that precisely these data are unlikely to be available.[146] Thus, any attempt to achieve causal apportionment is likely to be crude, although even this may be preferable to the "all or nothing" test considered above.[147] However, it is possible that quantitative and statistical methods may be applicable, if reliable data are

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1987 295 B.M.J. 1053 and Loveday v. Renton and Another Times Law Report, March 31, 1988.

[146]J. Stapleton, Disease and the Compensation Debate, op. cit., at p. 48.

[147]Discounts to reflect approximate degrees of causal responsibility may be reasonably easily proposed. Leaving aside the Kay case (because on the conventional view there was no causal input to the deafness by the defender), in McGhee a 50% figure, in Hotson either the 25% figure at first instance or simply an arbitrary sum to reflect loss of chance, and in Wilsher a 20% figure might be suggested. Of course, it may be argued that this is little or no advance upon the status quo. Thus in McGhee the condition may have been triggered by "innocent" dust, in Wilsher that the R.L.F. might have been caused (say) by patent ductus arteriosus and that in Hotson the boy had a high, 75%, chance of avascular necrosis before the negligence supervened. This, of course, brings full circle the original difficulties.

available,[148] although such tools must be used with great caution:

> "[T]he causation issues dealt with in civil actions and by medical scientists are not the same. In a civil action the causation issue is typically whether the plaintiff's injuries were caused by agent X. Population-based studies by medical experts cannot answer the question of individual causation; they merely show whether an individual is at an increased risk if he or she is a member of a certain group."[149]

(4) Finally, a reassessment of an even more fundamental nature is possible: reconsidering the two broad themes of the law in this area, viz. compensation and responsibility. It might be argued that the causal enquiry be elided totally, and these aims of the law be met, without sacrificing the responsibility goal, which might be satisfied by other means. In medical negligence, this might, for example, be by enhanced accountability. This dichotomy is accentuated where adverse medical outcomes such

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[148]Major contributions to this burgeoning literature include inter alia, Trial by Mathematics: Precision and Ritual in the Legal Process, L.H. Tribe, 1971 84 Harv. L. Rev. 1329 (a critical assessment); The Probable and the Provable, L.J. Cohen, Clarendon Press, Oxford, 1977; Probability Theory and the Law of Evidence, A.L. Tyree, 1984 8 Crim. L.J. 224; What is Bayesianism? A Guide for the Perplexed, D.H. Kaye, 1988 (Winter) Jurimetrics 161.

[149]Letter to the Editor, The Lancet, entitled "Proof of Causation", T.E. Kapshandy, 1992 339 The Lancet 876.

as peri-operative patient infection are involved. The immediate infection is caused by the agency of the bacterium or virus, but considering the aetiology of its source would be likely to prove very difficult indeed.[150] These broader matters are considered infra in the context of reform.

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[150]There appears to have been little written on this subject where it concerns negligence and compensation. However, this is included to some extent in the discussion in, Avenues of Compensation for Genetic Engineering Accidents, Y. Cripps, 1980 9 N.Z.U.L.R. 150 at pp. 150-157 and p. 161, although the author's primary concern is the New Zealand Accident Compensation Scheme. A further difficulty which would affect cases of medical negligence is that the agents liable to cause infection might be those which are sometimes normally harmless and found in hospitals. Genetically-engineered strains presumably are more readily distinguishable and identifiable and therefore would be less difficult to identify with a view to apportioning any potential legal liability.

Part IV

Chapter VI: Reform

Introduction

Thus far, this thesis has considered the main principles of the present law and its development. It has also attempted to demonstrate the ways in which it is unsatisfactory in its regulation of medical negligence. However, a further aim is to propose a systematic means of alleviating these difficulties. This part of the thesis therefore considers the question of reform. It must be emphasized that discussion is restricted to the law of medical negligence. The many broader issues in the so-called "compensation debate" are not considered, both by reason of the focus of this work and by dictates of space. Readers who wish to pursue these questions are referred to those works dealing specifically with them, in particular the excellent and comprehensive discussions to be found in Atiyah's Accidents, Compensation and the Law.[1]

This section outlines the approach adopted; thereafter, in the following chapter, the writer's proposals for reform are put forward. Firstly, however, the aims of delict and tort law are considered; these are essentially similar in Scots and English law.[2] In doing

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[1]Fourth edition, by Peter Cane, Weidenfeld and Nicolson, 1987, particularly chapters 18, 19, 21, 22 and 25.

[2]Readers are referred to the previous chapters on the substantive law.

this, the underlying goals which the proposed new system strives to meet are elucidated. Potential reforms, varying from some of the limited changes considered by the Pearson Commission[3], to extensive no-fault, or even needs-based, compensation schemes will then be discussed insofar as appropriate. It is argued that none of these possibilities would implement those desirable underlying aims of the law without serious reservations. It is submitted that the writer's proposals, in attempting to address individually the aims and principles involved, would go much further toward providing a satisfactory system than is at present the case.

We may summarise the various shortcomings which we have considered in the existing negligence scheme for dealing with medical malpractice within two categories. These comprise, firstly, the legal principles upon which this thesis focusses and, secondly, matters essentially of practice which have not been systematically analysed because of constraints of space. The former comprised the standard of care, the broader issues of the fault principle, and proof of causation. Criticisms of these were inter alia that the standard of care reflected adequately neither moral fault, nor the ascription of

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[3]Despite supporting the retention of tort generally, the Pearson Commission did, however, recommend more far-reaching reform for areas other than medical negligence, for example in road traffic reparation cases (Pearson Report, 1978, Cmnd 7054-1, vol. 1, ch. 18), vaccine damage (Report, ibid., vol. 1, at p. 370) and handicapped children (Report, ibid., vol. 1 at p. 370).

liability consonant with actual clinical responsibility and practice. The flaws in the corrective justice model become magnified in the context of medical negligence: not only do the general criticisms manifest themselves in this area of delict or tort, but the effect of indemnity insurance, vicarious liability[4] of health boards and authorities,[5] difficulties of detection[6] and proof and the operation of the substantive law itself all add to this, and are reflected in the relatively small number of patients[7]

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[4]Cf. the liability of a servant to indemnify his employer in respect of damages paid by way of vicarious liability (para. 10-90, Charlesworth & Percy on Negligence, R.A. Percy, eighth edition, Sweet & Maxwell, 1990).

[5]Rather than, for example, recognising the de facto responsibility of the consultant in charge. In other areas of professional activity in which the partnership is used, recognition of the de facto responsibility by the law is more readily achieved (e.g. firms of solicitors, in which the principal is liable for the acts of his fellow partners and his employees - it is in his interest to exercise sufficiently close supervision).

[6]By its nature, there appear to be no data on this. However, "[I]t has been estimated that some 5 1/2 million in-patients and 17 million new out-patients and accident and emergency department patients use our hospitals every year. It is also believed that there are some 200 million consultations with general practitioners every year. An average of some 15,000 formal complaints are made by in-patients every year whereas a much smaller number of formal complaints are made by patients of general practitioners." Medical Complaints Procedures, A.C. Taylor, at p. 8, in Medical Negligence, M.J. Powers, N.H. Harris, Butterworths, 1990. An example which may involve negligence relates to the death of a patient in hospital, where in Scotland a Fatal Accident Inquiry follows: e.g. Medicine and the Law: Hairline Fracture and Meningitis, D. Brahams, 1991 The Lancet 605.

[7]The Pearson Commission, op. cit., noted that whereas some payment was made in 86% of all personal injury claims (Report, vol. 2, para. 66) only approximately 30%-40% of medical negligence claims resulted in some compensation's being paid (Report, vol. 2 Table 11; see also vol. 1, p. 284, para. 1326).

compensated, on occasion highly[8] (especially in the U.S.,[9] where it has been argued that there is a litigation crisis in the professions[10]). Furthermore, there is now strong evidence that U.K. obstetric and gynaecological medical practice is influenced by medico-legal considerations,[11] i.e. that there exists significant practice of "defensive medicine".[12]

It may be that the medical negligence claims analysed were simply less meritorious than the general personal injury average. See also Medical Negligence: Compensation and Accountability, C. Ham et al., King's Fund Institute/Centre for Socio-Legal Studies, Oxford, 1988, which substantially endorses these various criticisms, particularly Table 1, at p. 8, and Figure 5 (page 12), showing an apparent increase in claim rates per unit head of population. These data do not, however, appear to be correlated with the population's actual contact with the medical profession and show widely differing rates between the two regions studied. This tends to confirm the near-impossibility of obtaining clear data upon trends in this field.

[8]For example Tombs v. Merton and Sutton Health Authority, 1991 (11 December) "The Scotsman" 2, in which a patient was administered carbon dioxide during anaesthesia, resulting in severe brain damage. The damages awarded amounted to £1.65 million; the operation had taken place four years previously.

[9]See "Diethylstilboestrol daughter" claim settled for $4 million, D. Brahams, 1991 The Lancet 1137.

[10]"It is only in the litigious U.S. that the astronomical premiums and awards threaten business and the professions. It is the liberalization of our legal system, which has not occurred in any other country in the western world, that has evoked this litigation crisis." Professional Liability, R.S. Emerson, R.M. Schwarz, 1983 New York State Journal of Medicine 69, at p. 71.

[11]Medicine and the Law: Worried Obstetricians, D. Brahams, 1991 The Lancet 1597.

[12]Change in obstetric practice in response to fear of litigation in the British Isles, M. Ennis, A. Clark and J.G. Grudzinskas, 1991 The Lancet 616. In Medical Malpractice, Harvard University Press, Cambridge, 1985, P. Danzon has put forward the view that in the U.S. there has been relatively little, or negligible, defensive medicine and concomitant waste of resources; in fact, additional investigations would have

In addition, trenchant criticisms have been made in respect of non-substantive factors. Thus the King's Fund study concludes that the legal procedures involved are lengthy and expensive for all parties; that patients may well experience difficulty in obtaining a suitably experienced solicitor or expert witnesses, and that the adversarial system tends to inhibit explanation and consideration, promoting instead obstructiveness, hostility and enmity.[13] The study concludes not only that substantial, long-term reform is required, but even that short-term measures are needed, primarily to ease access to justice. However, it has been argued that prognostications of a massive financial burden upon health authorities following Crown indemnity are unlikely to be realised:

> "the National Health Service...management executive...suggest that the media attention given to high settlements is unrepresentative of the true picture. Up to 1988, the total annual cost to the hospital service of paying part of defence organisation subscriptions was about £30 million. With transfer of indemnity in 1990, this £30 million was added to a combined fund of £50 million from defence organisations for payment of claims. The 1990/91 cost to the N.H.S. of medical negligence was around £40-45m in England. These figures are lower than those forecast. During 1990/91 only 30 applications were made to the Department of Health for help with claims above £300,000; expenditure on claims remains below 0.5% of total NHS revenue, and the NHS management executive emphasize that no money is drawn from funds allocated to patient

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improved patient care. Despite the now-conflicting evidence, it is speculated by the present writer that the insurance-based private medicine practiced in the U.S. would be likely, despite the so-called malpractice crisis, to lead to under-investigation.

[13]King's Fund study, op. cit., at p. 5.

> services.[14] From April 1, 1991, opted-out hospital trusts became directly responsible for all negligence costs incurred after that date. If settlements exceed 0.5% of their income, then trusts can borrow from either the Government or commercial lenders to meet the excess. The period of repayment would be set according to the size of the loan - e.g., 1 year for advances of below £100,000, but 10 years for loans over £900,000 - and costs arising from such borrowing should be borne by the relevant clinical department."[15]

Principally, the reforms suggested by the King's Fund study comprise greater availability of legal aid, balanced by improvements in the self-regulation and quality control of medical services.[16] Similarly, a report of the Royal College of Physicians has recommended the establishment of a no-fault scheme of compensation for medical negligence.[17] But before considering the spectrum of possible reforms, it is important to consider the aims of the law. Some consideration of these, it is suggested, provides the foundation necessary to evaluate the various options available.

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[14]Despite this, it is presumably possible that the original budgetary allocations reflect the perceived increase in costs of settling claims and thereby exerts a strong but concealed effect upon patient-care funds.

[15]"Noticeboard", "Exaggerated claims?", 1991 The Lancet 1340. Cf. The true cost of compensation, S.A. McLean, 1991 (17 December) "The Scotsman" 9.

[16]King's Fund study, op. cit., at p. 5.

[17]Compensation for Adverse Consequences of Medical Intervention, A Report of the Royal College of Physicians of London, 1990, at p. 22.

Various aims of the law of tort and delict have already been identified and discussed. As has been remarked, though, the quantity of analysis of these in the case-law is negligible,[18] and it is therefore to the literature that we must turn for assistance. Even here, there is minimal discussion of the law of medical negligence.[19]

The most commonly-described goals are "justice",[20] compensation,[21] deterrence,[22] retribution and the need for an inquest (or equivalent).[23] Others include appeasement of

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[18]The Advantages of Fault, W. McBryde, ibid. at p. 34: "[A] search through reported delict cases reveals very little that is said to justify basing liability upon fault."

[19]This discussion is restricted to those aims occurring in relation to liability for unintentional harm. Although these may incidentally be appropriate to analyses of the wider law of delict or tort, they are not necessarily applicable to such areas as intentional harms and quasi-delicts etc.

[20]This is a general term which includes notions of common-sense justice or morality, individual responsibility, and the moral basis which has at times been claimed for the fault principle (discussed supra); it is equivalent to "corrective justice".

[21]In this context the principle of scarce resources is inescapable.

[22]These three are considered in Atiyah's Accidents, Compensation and the Law, fourth edition, at p. 560, to be the principal aims.

[23]The last two are mentioned by D. Harris et al. in Compensation and Support for Illnes and Injury, Clarendon Press, Oxford, 1984, at p. 21. Pages 17 - 25 list and discuss the objectives of all the compensation mechanisms available.

the victim[24] and education.[25] In addition, McBryde has suggested the interests of the defender in justice, flexibility and the avoidance of categories,[26] although these, it is thought, need not exclusively be characteristic of or define a fault-based system of delict/tort[27] but may also apply elsewhere.[28]

However, most if not all of the various goals identified may be classified within one of the three major, over-arching aims: justice, deterrence and compensation. Thus, appeasement of the victim and the need for an inquest may be considered simply as limbs of the justice objective, and education as a partial re-description of the deterrent function. The defender's interest in justice, flexibility and the avoidance of categories are, it is thought,

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[24]The Aims of the Law of Tort, G. Williams, 1951 4 Current Legal Problems 137 at p. 138. This is closely related to retribution.

[25]New Zealand's Accident Compensation Scheme, L.N. Klar, (1983) 33 Univ. Toronto L.J. 80, at p. 92. This objective is similar to deterrence.

[26]See The Advantages of Fault, W. McBryde, 1975 20 J.R. 32, at p. 42 et seq.

[27]"Delictual liability is generally based upon fault. There is no warrant, however, for excluding instances of no-fault liability from its ambit, for the essential character of the law of delict is that it compensates for unlawfully inflicted injury, not that it usually requires fault for doing so." The Law of Delict, P.Q.R. Boberg, Juta & Co. Ltd., vol. 1 (Aquilian Liability), 1984, at p. 16.

[28]They are also of less relevance to medical negligence, cases of which may be discretely and readily identifiable, even if the aetiology of the condition concerned is not.

desirable goals, but which need not be specific to the delict process.

The aims for the delict or tort system do not necessarily support its continuation unchanged, though. Goals may be modified or even abandoned; they may be poorly realised in medical negligence law, and better attained by alternative means.[29] Such an approach has been urged on a wider scale than merely the law of medical negligence, in respect of which it has been said that

> "[T]he fact that the objectives of the tort system might be thought desirable does not justify retention of a system which achieves those goals so inefficiently, and in many respects not at all."[30]

It is argued that the objectives of compensation, deterrence and corrective justice or individual responsibility nevertheless represent generally laudable aims for the law of medical negligence.[31] Indeed, expressed at such a high level of generality and abstraction, it is

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[29]See, inter alia, New Zealand's Accident Compensation Scheme: A Tort Lawyer's Perspective, L. N. Klar, [1983] University of Toronto L. J. 80, and generally, Some Kiwi Kite-Flying, M. Vennell, 1975 N.Z.L.J. 254, recognising the benefits of the traditional tort approach.

[30]Atiyah's Accidents, Compensation and the Law, fourth edition, op. cit., at p. 552.

[31]And the delict or tort system. See, inter alia, Accidents, Costs and Legal Responsibility, S. Stoljar, 1973 36 M.L.R. 233.

almost impossible to dissent from them. They are retained as aims in the proposed reforms.[32]

It is, however, thought that those aspects of the law of medical negligence which have been considered demonstrate unsatisfactory results. The law has thus far attempted to satisfy the differing goals primarily by providing only one mechanism:[33] the action for damages for medical negligence.[34] This, it is suggested, has contributed substantially to the difficulties experienced under the current system. The philosophy of the law would be better achieved by discrete, independent mechanisms for the major objectives. Some indication of support for such a less adversarial approach may be gleaned from the following:

> "[S]olicitors undertaking work on behalf of plaintiffs are aware that many claimants (in my experience at least half) would not have consulted them had they been handled sympathetically by the doctors concerned once an adverse event had occurred. In the early stages, patients or their families are often not motivated by the thought of damages but rather by a wish to receive an explanation of what has happened together with expressions of sympathy

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[32]Although modified where appropriate: they are discussed infra.

[33]Omitting social security, which plays a negligible role in compensating directly for medical negligence.

[34]Others have been suggested, for example no-fault schemes and strict liability. See Compensating for medical mishaps - a model "no fault" scheme, D. Bolt, 1989 N.L.J. 109; A Theory of Strict Liability, R. Epstein, 1973 (University of Chicago) Journal of Legal Studies 151; for a general discussion of economic theories of deterrence, see, inter alia, ch. 4, Atiyah's Accidents, Compensation and the Law, Peter Cane, fourth edition, Weidenfeld and Nicolson, 1987.

> and regret as appropriate. The absence of these ingredients can cause bitterness in the patient which, if not cured at an early stage, may create an overwhelming desire to pursue a case to trial even if the expert evidence is against negligence having occurred."[35]

Before considering other legal aims, a question arises as to the provision of compensation. It seems that the tort or delict action generally is an expensive method of providing this.[36] The Pearson Report disclosed in 1978 that actions for medical negligence had taken longer on average, and resulted in a relatively lower level of recovery of damages, than was generally the case in tort litigation.[37] It has been suggested that the rate of claims in cases of medical negligence has increased,[38] although the evidence for this seems somewhat anecdotal and inconclusive.[39] It

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[35]Preliminary Legal Steps for the Patient, R. Vallance, at p. 102, in Medical Negligence, cit. sup.

[36]Compensation and Support for Illness and Injury, D. Harris et al., Clarendon Press, Oxford, 1984, at p. 327 et seq.; see chapter 12 (Review and Prospect) generally.

[37]The Pearson Report, op. cit., stated that "..at all stages medical negligence cases took longer than other personal injury cases. The average interval between the date of injury and the date when the claim was disposed of was nearly five years..". This was contrasted with a period of three or four years for other personal injury claims. (ibid., vol. 2, para. 242 at p. 67). Whereas "some payment is made in respect of about 86% of all personal injury claims" (ibid., vol. 2, para. 66 at p. 20), a much lower proportion of claims in respect of medical negligence succeeded, 30%-40% (ibid., vol. 2, table 11, at p. 19). The King's Fund study (op. cit. at p. 9 et seq.) tends to support and indeed bolster the criticisms of the action in respect of medical negligence.

[38]See the King's Fund study, op. cit., at p. 8.

[39]The King's Fund study cites primarily the large and undoubted increase in the cost of medical defence society indemnity premiums, which has now been affected by the

may also be pointed out per contra that the substantive law applicable has not changed fundamentally, tending to suggest that a conclusion on the evidence of an underlying increase may not entirely be warranted.[40]

If, as is argued in this thesis, there is no longer a requirement to retain a combined mechanism for legal goal-attainment, the compensation function in medical negligence need not continue to be performed by this expensive and slow means. It is therefore submitted that a new conduit for the distribution of compensation is required.[41] Research has demonstrated that it is more efficient, and less expensive, to compensate administratively than via the

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introduction of Crown indemnity. This increase substantiates the increasing cost of awards and settlements, but does not of itself establish that there is a rising underlying trend per head of medically-involved patients. The writer sympathises with the difficulties of gathering and analysing data in this notoriously difficult field.

[40]Although there have been matters of serious concern in the inception of the Crown indemnity scheme, such as its effect upon the health-care budgets of opted-out N.H.S. hospitals, at the time of writing, it is too early to determine this with clarity (although the fear must be that continued inflationary escalation in settlements may ultimately lead to a "cap" being put on liability in the individual case. Cf. the letter to The Lancet (quoted supra)).

[41]See generally Theories of Compensation, R. Goodin, 1989 9 Oxford J. Legal Studies 56.

courts,[42] and accordingly such a means of providing compensation is proposed.[43] Indeed, the Government has canvassed the idea of an arbitration scheme for medical negligence claims which would apply the same substantive law, including the Bolam test, and would reduce the costs of meeting the approximately 7,000 claims amounting to an average of £6,500 each which are made at present.[44] It has, however, been argued by a leading medical commentator that 95% of cases are settled out of court and that

> "[W]hat we need is not cosmesis but a cost effective no fault system combined with a strategy for reducing medical accidents. Britain could have a system like the Swedish one for about £50m, almost exactly the same as the amount paid out by the NHS for medical negligence in 1990. And a Swedish style system would mean that many more people were compensated with far less

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[42]Compensation and Support for Illness and Injury, D. Harris et al., Clarendon Press, Oxford, 1984, at p. 327. (See chapter 12 (Review and Prospect)) See also Pearson Report, op. cit., vol. 1, para. 83, at p. 26, to the effect that the operating costs of the tort system amount to approximately 85% of the value of the damages awarded, a very high proportion exceeding that of social security distribution (approximately 11%); and generally the King's Fund study (ibid.).

[43]Discussed infra. The "compensation debate" has recently been the focus of a major research study, which concluded inter alia that "[W]e believe, in the light of the data presented in this volume, that the future policy maker should plan to phase out all existing compensation systems which favour accident victims (or any category of them) over illness victims." Compensation and Support for Illness and Injury, D. Harris et al., supra, at p. 327.

[44]Arbitration for medical negligence claims, anon., 1991 B.M.J. 1156.

of the money ending up in lawyers' pockets."[45]

It is, however, the non-compensatory aspects of the writer's proposal which distinguish it from most other suggestions for reform, be they no-fault or needs-based approaches.[46] These issues are often overshadowed by the emphasis placed upon the conundrums of rational, realistic reform of the general compensation function.

Corrective Justice

Although it has been commented that "..the tort system focusses primarily on the obligation of the defendant to pay, rather than the entitlement of the plaintiff to be paid, compensation. Thus the fundamental goal of the tort system is corrective justice or fairness...",[47] we have seen that corrective justice provides a basis of doubtful validity for the fault principle. For the reasons considered supra, it is likely that these reservations apply more strongly in the case of medical negligence. A recent empirical study by Genn supports the view that in

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[45]Fiddling with medical negligence, R. Smith, 1992 B.M.J. 198 at p. 199. A footnote has been omitted in quotation, which refers generally to the King's Fund study (supra) for the estimated cost of £50m for the cost of such a scheme.

[46]Some commentators have also indicated a need to strengthen medical professional accountability. See particularly the King's Fund study, op. cit., at pp. 33-34, and also Medical Negligence and No-Fault Liability, C. Clothier, 1989 The Lancet 603.

[47]Atiyah's Accidents, Compensation and the Law, by Peter Cane, fourth edition, Weidenfeld and Nicolson, 1987, at p. 560.

reparation claims in which an insurer (or arguably any similarly-experienced defending organisation) is involved,

> "..the parties to personal injury actions do not meet on equal terms and their objectives are diametrically opposed. It has been argued....that there are both structural and situational inequalities between the parties in personal injury litigation and that the effect of these inequalities is evident throughout negotiations and the final out of court settlement of a claim....[T]he plaintiff is in a disadvantaged position from the outset."[48]

Nevertheless, the present writer considers that the aim of emphasizing individual responsibility, if detached from joint implementation with the fault principle, exhibits merit and is thus retained in the proposed scheme. This perhaps elusive goal is, however, modified in the light of the criticisms of it, and of the closely-related fault principle,[49] which have already been considered.[50] It is thus sought to be attained in the proposed scheme only partly on the traditional, i.e. "individual", basis. Rather, in the sense of promoting individual responsibility in the professional medical context, it may be satisfactorily achieved by a combination of strengthened

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[48]Hard Bargaining, H. Genn, Clarendon Press, 1987, at p. 163.

[49]The two are to a degree co-extensive, as corrective justice is one of the main virtues claimed in favour of the fault principle.

[50]See the introductory section supra, and chapter IV, supra, on the fault principle, incorporating discussion on the principle of corrective justice as a possible justification for a moral basis for the fault principle.

professional accountability and a partly patient-driven quality audit.

This departure from the conventional view is thought to be supported in part by the individual doctor's (as well as his profession's) commitment to high professional standards and probably also to self-improvement and keeping up to date. These are perhaps most suitable for "ordinary", i.e. non-medical,[51] cases of negligence in which no medical or indeed professional ethic, which may suggest a particular legal approach to the exercise of that calling, is involved.

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[51]Or non-professional.

Deterrence: Introduction

Whereas there is almost universal agreement in principle that some means of providing compensation is essential, and even though deterrence is also a recognised goal, the need for it is less clearly demonstrated.[52] Some commentators have doubted the ability of the delict or tort action to provide effective, consistent deterrence, especially in negligent, as opposed to intentional, delicts and torts:[53]

> "[A] second important objective of the tort of negligence is to deter people from acting negligently: many accept, as a matter of intuition, that the knowledge that the law will

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[52]This work is of course restricted to medical negligence. Thus the intentional delicts, which, being "conscious", are much more amenable to deterrence, are excluded, as is the deterrence of "ordinary", or non-professional, delicts and torts. Occurring potentially in any aspect of the tortfeasor's activities, they are therefore much less amenable to prediction and prevention than is the case with a professional activity.

[53]For example, Compensation and Support for Illness and Injury, D. Harris et al., Oxford Socio-Legal Studies, Clarendon Press, Oxford, 1984, ch. 12.; Deterrence and Accident Compensation Schemes, C. Brown, 1978 17 Univ. Western Ontario L. Rev. 111; Common Sense Morality and Accident Compensation, S. Lloyd-Bostock, 1980 Insurance L. J. 331. However, H.L.A. Hart has commented that, " "[E]ven if a person admits that he occasionally makes a negligent mistake, how in the nature of things, can punishment for inadvertence serve to deter?" But if this question is meant as an argument, it rests on the old, mistaken identification of the "subjective element" involved in negligence with "a blank mind", whereas it is in fact a failure to exercise the capacity to advert to, and to think about and control, conduct and its risks. Surely we have plenty of empirical evidence to show that,..."punishment supplies men with an additional motive to take care before acting, to use their faculties, and to draw upon their experience." " (Punishment and Responsibility, op. cit., ch. VI (Negligence, Mens Rea and Criminal Responsibility) at pp. 156-157 (references and footnotes omitted); see chapter IV on the moral basis of fault, supra).

> compel the negligent actor to pay for the harmful consequences of his negligence will have some general deterrent effect. However, the deterrent function of the law is blunted by various factors. First, it operates only if the carelessness actually causes harmful consequences, and even then, the amount of damages depends on the relative severity of the injury, not on the degree of blame attaching to the conduct which caused it: a trivial mistake can cause serious injury, while flagrant carelessness may cause only a minor injury, or none at all. Secondly, the law operates only if the victim can produce adequate proof of the actor's carelessness. Thirdly, the damages are normally paid, not by the careless person, but by his insurance company or his employer (under the legal doctrine of vicarious liability)."[54]

But even if deterrence is accorded substantial theoretical importance, the tort and delict system would still be subject to criticism:

> "....there are strong reasons to doubt that the tort system is very effective as a deterrent or accident prevention mechanism, and while modern economic analysts of law see deterrence as the main function and rationale of the tort system, the practical barriers to the fulfilment of the theoretical deterrence function of tort law are so substantial that it is unsatisfactory to attempt to justify the tort system in terms of the goal of deterrence."[55]

It has been argued that the barriers to the achieving of deterrence in medical negligence litigation are more substantial than elsewhere in the law of tort or delict. This is despite the professional medical duty and ethic to place the patient's interests above the doctor's and to

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[54]Compensation and Support for Illness and Injury, D. Harris et al., supra, at p. 20.

[55]Emphasis added. Atiyah's Accidents, Compensation and the Law, op. cit., at p. 560.

provide a high and improving standard of care, both of which should lessen the need for deterrence. Recent medical research, demonstrating the existence of "defensive" obstetric practice in the United Kingdom, tends to suggest that the operation of tort, and by implication its deterrent effect, is counter-productive and does not therefore necessarily benefit the standard of medical care.[56] Other commentators, who focus on specific areas,[57] consider that such niches are in principle of intrinsically and necessarily low susceptibility to deterrence.[58] It is left to the so-called "tort lawyers" to argue in favour of the retention of the old-fashioned, but in their view real and valuable, virtues of deterrence in delict and tort.[59] These arguments re-emphasize the possibility, and common-sense morality, of deterring negligent conduct as being of sufficient importance to justify, in effect, the "accident

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[56]See Change in obstetric practice in response to fear of litigation in the British Isles, M. Ennis, A. Clark and J.G. Grudzinskas, supra: "[H]owever, the anxiety of doctors about litigation and the increased cost of carrying out more and perhaps unnecessary tests may become an intolerable burden on the National Health Service" (ibid., at p. 618).

[57]For example, so-called long-latency man-made disease. See Disease and the Compensation Debate, J. Stapleton, Clarendon Press, Oxford, 1986, ch. 2.

[58]Notwithstanding the views of H.L.A. Hart, supra. See inter alia Deterrence and Accident Compensation Schemes, C. Brown, 1978 17 Univ. Western Ontario L. Rev. 111; and ch. 12 in Compensation and Support for Illness and Injury, D. Harris et al., supra.

[59]See The Advantages of Fault, W.W. McBryde, op cit., and New Zealand's Accident Compensation Scheme: A Tort Lawyer's Perspective, L. N. Klar, [1983] 22 Univ. Toronto L. J. 80.

preference" in tort damages, and most of the other vicissitudes alleged by reformers. It is interesting to note that elements of economic theories of tort may be appearing in the law of medical negligence. The Medical Insurance Agency has offered to doctors an insurance-type contract of indemnity which requires to be in force at the time of a claim for indemnification to follow, unlike traditional medical defence body cover. However, risk-related premiums, originally announced by the Medical Protection Society, have been followed by the Medical Insurance Agency, which has reportedly offered a discount to members and fellows of the Royal College of General Practitioners, who are thought to be at lower risk of a claim.[60] The present form of Crown indemnity does not, of course, affect the arrangements for general practitioners.

In addition to these substantive matters, it is submitted that the deterrent effect is not treated systematically and consistently even within the category of medical negligence. This is because it is only where harm actually occurs, coincident with proof of fault and causation, that liability is visited upon the defender or tortfeasor. The coincidence of these factors must seriously restrict the actual effect of the tort and delict system. Although determining the numbers of cases in these categories is practically impossible, it is submitted that

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[60]Letter to the The Lancet, entitled "Qualifications and quality of care", by W. McN. Styles, 1991 The Lancet 1352.

some must exist in which negligence per se goes undetected and therefore unregulated.

The result of this must be that the deterrent effect is either weakened, or non-existent, in those cases where no harm occurs. By implication it also weakens the deterrent effect exerted by the whole law of medical negligence. Even if this is disputed, perhaps on the view that it may be fortuitous whether harm occurs or not and that this is the important matter,[61] the law still does not deal consistently with negligent conduct. It is submitted that this is unsatisfactory.

Arguments may be advanced per contra. For example, it might be said that if no loss or damage occurs, then there is no need for anything further to be done; by definition, no-one has come to any harm. The present writer disagrees with this. By not taking steps beyond the minimum to deter negligent conduct, some implicit condonation by the law of a certain level of negligence occurs, and the likelihood of future negligent conduct is thereby also increased.[62] Even if this argument is not accepted, the law is still not dealing consistently with negligent conduct, and it is thought that this, again, is unsatisfactory. A further argument is that, as a practical matter, a compromise must

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[61]Although it is thought that fortuitousness is an unsatisfactory criterion upon which to base a decision whether or not to award damages.

[62]And, incidentally, the risk of harmful negligence - which it is the law's present policy to reduce by deterrence.

be found between a reasonable level of deterrence and the disproportionate effort, or even impossibility, of deterring all negligent conduct.

At first blush, this seems eminently reasonable. It is, however, not beyond dispute. This is partly because it is predicated upon the delict or tort law model, which in its present form has an intrinsic limit to the amount of negligence it is capable of deterring, as we have seen.[63] However, if the unfulfilled underlying negligence-prevention philosophy is accepted, and another way can be found to deter more or all negligence,[64] then it is thought that this goal should be pursued. However, the writer acknowledges that ultimately, the deterrence of all negligent conduct is likely to be impracticable. It is, nevertheless, contended that a greater degree of prevention can, and should, be achieved in principle and in practice.

It is submitted that it is helpful at this point to draw a distinction between professional activities, especially medical, and "ordinary" negligence. The former generally demonstrate unintentional, i.e. negligent, wrongs. Non-medical or non-professional "ordinary" negligence includes various other types of wrong, be they statutory, strict liability or intentional. A further factor is relevant: doctors are committed to provide improving and ethical

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[63]This is because of the requirement for fault and causation to be established in addition to the harm.

[64]Or to deter more consistently.

treatment of patients. This ethic, which exists probably in one of its strongest forms in the medical profession may alter the aim and method of achieving professional deterrence: a coercive, ex post facto, approach is argued to be relatively less appropriate.

By contrast, "general" negligence, outside the confines of professional activities, may arise out of almost any activity which the defender undertakes in the course of his daily or working life. Clearly, this is likely to render deterrence much more difficult; the variety of activities potentially involved is almost unlimited. Further, the incarnation and method of deterrence need not, at least initially, be the threat of a sanction, either legal or professional. Strengthened professional education may be a more effective means of reducing the occurrence of negligent episodes as part of a wider response.

Although it could be suggested that resource implications and difficulties of detecting negligent conduct per se militate against an expansion of deterrence, the law has, in other areas, deemed it sufficiently important to regulate conduct in itself even though little harm may have resulted. This is evident in several areas. One is in the criminal law; it is well-settled that

attempted crimes can be punished.[65] One rationalization of so doing is that society has been harmed, by the intention and the steps taken towards commission of the crime by the individual and that this is harmful to society and to that individual. Although this may not constitute a full justification for the prosecution of attempted crimes, it does condemn the attitude of mind as well as the actions taken. It is likewise important to note that no actual harm has occurred, other than the possibilities adverted to above.[66]

It is submitted that it is possible to draw some conceptual parallels between non-harm causing negligence and criminal attempts. Although there is nothing appropriate in the civil law of negligence corresponding to "preparation", there is nevertheless in an "inchoate delict" an absence of positive harm, and a presence of a mental element, in a loose sense including negligence. It is thought that, although negligence is perhaps less harmful to society than criminal attempts, in principle the same reasons should apply to deterring negligence.[67] This

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[65]See, The Criminal Law of Scotland, G. Gordon, second edition (and Second Cumulative Supplement, 1992), Greens, 1978, ch. 6, part I.

[66]For a detailed discussion of theories of attempted crimes, see The Criminal Law of Scotland, G. Gordon, second edition (and First Supplement, 1984), Greens, 1978 at pp. 165-190. Gordon considers that Scots law follows the perpetration-preparation test (see p. 190).

[67]Even if the limitation is accepted that some non harm-causing negligent "act" must have occurred. This might well be needed to allow detection of the negligence in appropriate cases,

is particularly so as, a priori, negligence, as argued by delict and tort lawyers, is worth deterring. All, then, that is urged by the present writer is that this be done more consistently and effectively.

Other areas of law also display regulation of conduct, sometimes irrespective of harm. Examples include contracts uberrimae fidei (insurance) and some fiduciary aspects of other contracts. In insurance contracts, the element of disclosure is deemed to be of sufficient importance as to warrant protection.[68] Examples of good faith enshrined in the law include aspects of the law of agency[69] and of partnership.[70]

These examples demonstrate that the law considers conduct, and trust, in certain situations to be worth regulating even where little or no loss or damage has taken place. Recognition of this in the medical context implies a more thorough and consistent approach to deterrence. A further difficulty which stalks deterrence theory is, of course, that of fault liability insurance. In the general

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and also suffices to avoid the precept of the criminal law that guilty intention on its own cannot be punished.

[68]Introduction to the Law of Scotland, Gloag and Henderson, eighth edition, Greens, 1987 at pp. 422-423.

[69]Introduction to the Law of Scotland, Gloag and Henderson, supra, at pp. 318-319; Scots Mercantile Law, E. Marshall, Greens, 1983, ch. 1 at pp. 24-27; An Outline of the Law of Agency, Markesinis and Munday, second edition, Butterworths, 1986, ch. 3.

[70]Partnership Act 1890, ss. 28-30.

context of tort law it has been said that,

> "[T]he development of liability insurance has altered administration and financing of the tort system out of all recognition...
> "For example, since the vast majority of tort claims are settled out of court, the behaviour of insurance companies is at least as important as what lawyers and courts do, to an understanding of the way the tort system is administered in practice. Again, reading a book on the law of torts might well lead one to think that people who commit torts are constantly being called upon to pay damages or compensation for what they have done. Nothing could be further from the truth. "People who commit torts very rarely pay compensation to anyone although the courts certainly seem largely to ignore this fact. When tortfeasors did pay damages, lawyers were very concerned to justify this result. But now that they do not generally do so, most lawyers seem to have little interest in the question of financing."[71]

The position in the law of medical negligence differs somewhat, inasmuch as damage to a medical man's professional reputation is likely to be perceived very seriously by him. Two other factors should be mentioned. The first is that the defence unions and health board or authority are likely to settle (in particular) indefensible cases rather than add the expenses of trial to an otherwise inevitable judicial award of damages. This state of affairs is most likely to obtain in the most culpable cases of negligence - arguably those in which the deterrent effect of the trial is most needed, but in which it is

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[71]Atiyah's Accidents Compensation and the Law, Peter Cane, fourth edition, Weidenfeld and Nicolson, 1987, at p. 6.

largely or wholly absent.[72] Thus the worst cases may well be those which are never subject to forensic scrutiny. The absence of risk-related or claims-related insurance in medical practice only adds to this unfortunate result. This is, in effect, perpetuated by the introduction of Crown indemnity, perhaps to a greater extent if the health board or authority is inclined to settle cases rather than risk additional expense in defending them itself. This is also likely to be the case where N.H.S. hospitals have opted-out of health board financial control. Professional indemnity insurance has shielded the doctor to a substantial degree from the financial consequences[73] of his negligent actions,[74] as does Crown indemnity. Secondly, in cases where vicarious liability is involved, criticisms may also be made. The deterrent effect must be weakened by being exerted partly or wholly against a single, monolithic defender, such as a health board, which has varying or little direct input into many professional tasks carried out by employees. Where the negligent episode was not

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[72]On the basis of personal contacts, the writer is aware of out-of-court settlements in which a condition precludes the discussion or publicising of the level of award. This robs the current process of an important potential deterrent/educative effect.

[73]Especially in the absence of risk-related premiums.

[74]This is, on balance, to be welcomed, because with settlements now reaching £1 million pounds, few if any doctors would be likely to be able to fund settlement; those involved would be driven from professional practice, probably to the long term detriment of the population as a whole. Defensive medicine might well become a significant problem in this case as well.

attributable to want of care in a system of work or similar matter for which the employing health body was responsible directly, the attribution of liability in respect of a single lapse of concentration by the doctor, perhaps through extended hours on duty, may well exert little preventive or deterrent effect in future. Nor is the de facto supervisory responsibility of the consultant in charge reflected in the law of vicarious health-professional liability, unless in the relatively unusual case (for example) of negligent over-delegation or a serious failure to supervise. Whereas the criticism in the passage quoted supra may not apply directly to this area, it is submitted that there are very fundamental difficulties in applying the conventional concepts of deterrence to it.

In conclusion, the present writer argues that since the fundamental purpose of deterrence is negligent-mishap prevention, it is therefore wise to retain it: the desirability of this, as such, is difficult to contest. This would appear to be so even if only a few episodes of medical negligence are avoided.[75] Further, it seems relatively unimportant whether this is achieved, as is suggested, by means other than the present action for medical negligence. Indeed, in the writer's submission, the use of alternative means is ultimately likely to

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[75]Although if highly expensive, ultimately a cost-benefit analysis might exclude this.

increase the effectiveness of deterrence. It would in turn lead to a reduction of treatment rectification costs and in compensation payable.

It is also argued that the concept of retributive justice plays a very small role in deterrence. One reason for this is that the professional medical activity concerned involves the doctor actively helping the patient. The intentional delict or tort is extremely unusual in medical cases; a negligent episode may be catalysed or caused by overwork or inexperience. In such a context a retributive justice element is thought to be inappropriate and should, as a matter of public policy, be minimised as far as possible. Indeed, a preventive approach would be likely to reduce compensation costs and improve the standard of care.[76] It has already been suggested that some patients contemplating litigation may wish an explanation for a mishap, or unsuccessful outcome, which may be contrary to expectations or difficult to understand.[77]

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[76]See Theories of Compensation, R.E. Goodin, 1989 9 Oxford J. Leg. Studies at p. 70 et seq.

[77]Supra. Increased professional accountability has been stressed by various commentators: Medicine, Patients and the Law, M. Brazier, Penguin, 1987, esp. chs. 7-9; Medical Negligence: Compensation and Accountability (Briefing Paper No. 6), C. Ham et al., King's Fund Institute/Centre for Socio-Legal Studies, Oxford, 1988; Medical Negligence and No-Fault Liability, C. Clothier, 1989 The Lancet 603.

Options for Reform

Many suggestions have been made for reform to the law of medical negligence. They may be grouped roughly according to the extent of the reform proposed, and thus range from the relatively minor, such as altering the burden of proof, to major reforms such as no-fault compensation schemes and beyond. The compensation aspect of the litigation process has been the most strongly debated, and it is therefore proposed to devote the main thrust of this discussion to the non-compensatory aspects of the process. However, it is worth remarking that the compensation issue must be seen in perspective. Not all nations are sufficiently prosperous as to be able to contemplate awarding compensation for medical negligence, or indeed many other heads of compensation generally. Those countries which can do so are relatively prosperous and fortunate. However, even in these nations, the principle of scarce resources is inescapable: unlimited funds are not available for compensation for medical negligence or indeed other needs, and limited resources require to be restricted in various ways if politico-economic strife is to be avoided.

Restricted Reforms

Although the approach of the Pearson Commission[78] and its recommendations have been powerfully and systematically criticised,[79] its Report did consider reform of the law of medical negligence, in respect of which it said, "[O]ur evidence showed that there was considerable dissatisfaction with the present position and some unease about the future".[80]

One possibility discussed was a reversal of the onus of proof,[81] in order to reduce what was accepted as a disadvantage to medical negligence plaintiffs.[82] The burden

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[78]Pearson Report, cit. supra, ch. 24, vol. I, deals with medical accident/injury.

[79]e.g. Disease and the Compensation Debate, J. Stapleton, Clarendon Press, Oxford, 1986.

[80]Report, vol. 1, op. cit., at p. 285.

[81]Report, vol. 1, ch. 24, p. 285, para. 1336 et seq. These were discussed in addition to substantive reforms, such as strict liability and no-fault compensation, in respect of which the Commission concluded that they were unwarranted. It must be added that at the time the Commission took evidence, the medical profession opposed the introduction of a no-fault scheme.

[82]"We were impressed by the difficulties facing a patient who wishes to establish a case, but we doubt if the confidentiality of medical records adds significantly to the plaintiff's difficulties in view of the court's powers to order disclosure", Pearson Report, op. cit., vol. I, at p. 287. "The proportion of successful claims for damages in tort is much lower for medical negligence than for all negligence cases. Some payment is made in 30-40 per cent of claims compared with 86 per cent of all personal injury claims", Pearson Report, 1978, op. cit., vol. I, ch. 24, at p. 284.

on such parties is still acknowledged today:

> "[T]he difficulties of plaintiffs in medical negligence cases are increased by the understandable reluctance of the courts, on the ground of their lack of competence to do so, to condemn as careless methods of treatment which the defendant may be able, with the assistance of expert witnesses, to show were not unusual."[83]

The reforms canvassed by Pearson were directed at easing plaintiffs' paths to compensation; other issues were barely mentioned. In summarising the evidence, the Commission noted that "[I]f tortious liability were abolished, there could be some attempt to control doctors' clinical practice to prevent mistakes for which compensation would have to be paid by some central agency".[84] The only non-substantive reform upon which evidence was taken was that of a reversed burden of proof. The Report does not state whether this would apply only to proof of negligence[85] [86] or of causation

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[83]This indictment of the standard of care and its proof is to be found in The Modern Law of Negligence, R. A. Buckley, Butterworths, London, 1988, at p. 285.

[84]Report, op. cit., vol. I, p. 287, para. 1342.

[85]Contributory negligence is a rara avis in such climes. Res ipsa loquitur might, of course, apply. However, the low observed incidence of success of the latter in the case-law may be because "barn door" cases are settled out of court as indefensible. Thus, marginal cases may be those litigated most often, in which the non-compensation aims of the law are needed less than in the former cases. By definition, if the issue of negligence is not extreme, res ipsa loquitur is less likely to be relevant.

[86]See Saunders v. Leeds Western Health Authority, (1985) 129 Sol. Jo. 225 (child's prolonged cardiac arrest during operation and brain damage; the defendants' explanation of air embolism to defeat the maxim was rejected); Clarke v. Worboys, The Times, 18 March 1952 (burn caused during treatment with electrical appliance; res ipsa loquitur); cf. Brazier v. Ministry of Defence, [1965] 1 Lloyd's Reports 26 (res ipsa loquitur

or both. In its favour, it was argued that such a change would all but remove the plaintiff's difficulties in "obtaining and presenting his evidence".[87] [88] This was said to be partly because doctors were in a better position to determine these issues than the plaintiff. The Commission, however, accepted that the arguments against were stronger, citing a potential increase in claims and defensive medicine as likely consequences.[89]

No doubt these concerns were valid. But it is necessary to consider them in the present context. The medical profession has perceived an increase in litigation and in the cost of settlement of claims.[90] Whether this accurately reflects the underlying trend is not clear, but the perception is undoubtedly real.[91] It has now led to the

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displaced, where a needle broke) and Levenkind v. Churchill-Davidson, [1983] 1 Lancet 1452 (res ipsa loquitur rebutted in evidence).

[87]Pearson Report, op. cit., vol. I, p. 285.

[88]In Cassidy v. Ministry of Health [1951] 2 K.B. 343, the Court of Appeal accepted that a "prima facie case", in the words of Denning L.J. (as he then was) had been made out following the patient's leaving hospital with four fingers disabled rather than two ([1951] 2 K.B. at p. 366, per Denning L.J.).

[89]Pearson Report, op. cit., vol. I at p. 285.

[90]This latter is certainly substantiated. See the King's Fund study, op. cit., especially chapter two.

[91]The large increases in professional indemnity fees for the profession, precipitating the introduction of Crown indemnity in January 1990 have played a large part in this. See Medical Negligence and No-Fault Compensation, A. F. Phillips, 1989 J.L.S.S. 239.

profession's espousal of the principle of no-fault compensation.[92] Thus, the Pearson Commission's defensive medicine argument may well already apply. Although the Commission's views on the burden of proof might change if it were now to re-consider the matter, it seems clear that the courts will construe the burden traditionally and therefore strictly. Despite the decision in Clark v. McLennan and Another,[93] [94] the House of Lords, in Wilsher v. Essex Area Health Authority[95] and in Kay's Tutor v. Ayrshire and Arran Health Board[96] has emphasized that the requirement of proof of causation by the plaintiff (or pursuer) on the balance of probabilities still applies.[97] Nevertheless, to

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[92]See No-fault compensation - the B.M.A. proposals, by David Bolt: ch. 6 in, No Fault Compensation in Medicine, ed. R. D. Mann and J. Havard, Royal Society of Medicine Services Ltd., 1989.

[93][1983] 1 All E. R. 416. "Where there is a situation in which a general duty of care arises and there is a failure to take a precaution, and that very damage occurs against which the precaution is designed to be a protection, then the burden lies on the defendant to show that he was not in breach of duty as well as to show the damage did not result from his breach of duty. I shall therefore apply this approach to the evidence in this case" per Pain J., [1983] 1 All E. R., at p. 427 g - h.

[94]See Medical Negligence - the Burden of Proof, M. A. Jones, New Law Journal, 6 January 1984, p.7.

[95][1987] 2 All E. R. 909

[96]1987 S.L.T. 577

[97]Lord Wilberforce's speech, in McGhee v. National Coal Board 1973 1 W.L.R. 1 was disapproved by Lord Bridge in Wilsher, supra, as a minority view. See Further Reflections on Medical Causation, A. F. Phillips, 1988 S.L.T. (News) 325, and Harrington v. Essex Area Health Authority, The Times, 14 November 1984, holding that proof of two possible causes of the harm without being able to distinguish between them did not discharge the burden of proof on the plaintiff.

require a defender in general to refute a claim brought against him, in all but the most crass cases is to take a dangerous step, in effect toward allowing recovery of damages based substantially upon the pursuer's assertion. This conflicts with the difficulty, acknowledged in the Pearson Report,[98] that a plaintiff faces in establishing a case in an unknown and uncertain scientific discipline - whilst he may have been unconscious. This suggests that the cost of this amelioration is outweighed by the potential for abuse; however, Dugdale and Stanton comment that,

> "...although a departure from common professional practice does not shift the formal burden of proof, it will, in many cases, constitute the best available evidence that the defendant was negligent. It will therefore help to satisfy the burden of proof which rests on the plaintiff".[99]

It might also be possible to ease the plaintiff's task by readier disclosure of case-notes[100]; indeed, there seems to have been a trend towards this in recent years, particularly in England.[101] To institute what would amount

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[98]Discussed supra.

[99]Professional Negligence, A. M. Dugdale and K. M. Stanton, second edition, Butterworths, London, 1989, at p. 245.

[100]Ending "forensic blind man's buff", C. Dyer, 1987 B.M.J. 1407; Medicine and the Law: pre-trial exchange of expert evidence to become normal practice in medical negligence actions, D. Brahams, (23 May) 1987 The Lancet 1215.

[101]From personal contact with the author, the defence unions' normal policy is to recommend the release of notes at least to a "third doctor". Health authorities generally are co-operative too, although on anecdotal evidence it appears that problems more readily arise in that case. At the time of writing, it remains to be seen how the introduction of Crown

to a de facto presumption of negligence following a (possibly) superficially meritorious claim is risky; whether such a reversal would allow adequate safeguards against unfounded litigation is doubtful. A larger scale reform might answer the patient's difficulties, and retain a more satisfactory balance for the doctor's legitimate interests. These reforms, the next larger in scale, are exemplified by the no-fault compensation schemes which have been established in New Zealand and in Sweden. It is to these that we now turn our attention.[102]

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indemnity in early 1990 will affect matters. To an extent this will bring litigation against N.H.S. hospitals under the control of the health boards and authorities, although this will not apply to those hospitals which have opted out. N.H.S. (and private) general practitioners will require to continue to fund successful claims for negligence from their defence unions' indemnity policies.

[102]See the discussions inter alia in, Principle and Pragmatism in the Compensation Debate, K. S. Abraham, 1987 7 Oxford J. Legal Studies 302; New Zealand's Accident Compensation Scheme: A Tort Lawyer's Perspective, L. N. Klar, [1983] Univ. Toronto L. J. 80; The Advantages of Fault, W. W. McBryde, op. cit.; Medical Negligence and No-Fault Liability, C. Clothier, 1989 The Lancet 603.

No-Fault Compensation Schemes: Introduction

As the name implies, the essence of a no-fault compensation scheme is that the requirement to prove fault is removed. Causation and, of course, loss or damage must still be established by the claimant. A no-fault scheme differs from strict liability in that there is no direct one-to-one relationship between the source of payment of damages (more accurately, compensation) and the person who has caused the injury. A central fund is established which disburses compensation, although those who engage in the activities producing the need for compensation may be required to contribute to it, perhaps in some relationship to the degree of risk which their activity produces if this can be calculated.

The no-fault schemes[103] introduced in New Zealand and Sweden[104] are of differing types.[105] The former demonstrated

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[103]See, inter alia, Medical Negligence and No-Fault Compensation: Background to the Current Debate, A.F. Phillips, 1989 J.L.S.S. 239.

[104]See Compensation for Injury in Sweden and Other Countries, C. Oldertz and E. Tidefelt, Juristforlaget, Stockholm, 1988: (unnumbered) chapter entitled, "The Swedish System", (pages 17-90).

[105]Discussed infra. They are not the only such schemes, but are the most prominent and extensive examples. For example, Finland has introduced a scheme covering medical mishaps, largely modelled on the Swedish antecedent, in addition to its well-established traffic- and employment-accident no-fault insurance schemes. See No Fault Compensation Finnish Style, D. Brahams, 1988 The Lancet 733.

a very broad approach in which all "personal injury by accident" (including medical "accidents") is compensated,[106] and the latter a narrower scheme aimed only at medical mishaps, although Sweden also boasts in addition discrete road traffic accident, and employment injury, no-fault schemes. Both schemes constitute relatively inexpensive methods of providing compensation, recent figures showing that the New Zealand scheme cost 7% in administration charges and its Swedish counterpart 16%.[107] This is substantially less expensive and more efficient than the tort and delict system operating in the United Kingdom. In the light of the present U.K. approach to medical negligence, we may find the following general analysis of compensation in the tort system also applicable to medical negligence:

> "[F]inally, it is worth noting that a major advantage called in aid to justify the change from tort liability to no-fault compensation is that the administrative costs of a no-fault system are usually much less than those of a tort system. For example, the Pearson Commission found that under the tort system the administrative cost of delivering £1 of compensation was 87 pence, while the cost of delivering £1 of social security benefits was only 11 pence. In the year to March 1979 the

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[106]See Accident Compensation in New Zealand, A. P. Blair, Butterworths (Wellington), second edition, 1983. Blair discusses the term "personal injury by accident" inter alia in chapter four. The term, he says at p. 27, was originally introduced by the Accident Compensation Act 1972, and is more recently defined by s. 2 of the Accident Compensation Act 1982 to include, inter alia, "(t)he physical and mental consequences of any such injury or of the accident: (ii) (m)edical, surgical, dental or first aid misadventure...".

[107]King's Fund study, op. cit., at p. 21 and p. 23.

cost of handling claims in the New Zealand Accident Scheme amounted to about 8% of the benefits paid. It does not follow from this that the tort system is too expensive, because it may be argued that the tort system serves goals and values which by their nature are expensive to secure - for example the highly individualised nature of the damages assessment process in the tort system is inherently expensive. But since so many people receive no compensation under the tort system, and given that the administrative cost is so substantial, it is necessary to ask very seriously whether the tort system is worth what it costs. It is difficult to answer this question other than negatively."[108]

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[108]Atiyah's Accidents, Compensation and the Law, by Peter Cane, op. cit., at p. 565.

New Zealand

The New Zealand Accident Compensation Acts 1972 and 1974, as amended, brought the Accident Compensation Corporation and with it the ambitious New Zealand no-fault scheme into existence, originally in Spring 1974.[109]

The ideal[110] was to compensate all personal injury by accident, classified principally by circumstances of occurrence, i.e. whether in the course of employment, in road traffic accidents or within a miscellaneous category mainly comprising accidents to those outwith the other two funding categories.[111] By far the largest single source of funding for the scheme has been a levy upon employers, the next largest being that upon users of motor vehicles, and then by contributions from taxation.[112] However, the overall aim of the scheme was that all accidents, being both unexpected and not deliberately sustained by the victim, were to be compensated. This, however, was

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[109]See Medical Negligence and No-Fault Compensation: The Background to the Current Debate, A.F. Phillips, supra.

[110]For a discussion of the background to the genesis of the Woodhouse Report, the engine for reform, and the scheme itself, see Compensation for Personal Injury: A Requiem for the Common Law in New Zealand, G. Palmer, 1973 21 American Journal of Comparative Law 1.

[111]See infra.

[112]See infra and the King's Fund study, op. cit. at p. 21 and Medical Negligence; also No-Fault Compensation: Background to the Current Debate, A.F. Phillips, op. cit.

qualified, particularly in the case of medical accidents, which include medical, surgical, dental or first aid misadventure. Excluded from compensation are the occurrence and normal progression of the processes of disease, ageing and infection. Thus, its coverage in respect of medical matters was significantly wider than negligent treatment only. It therefore includes non-negligent errors of judgment by the doctor and unforeseeable sequelae,[113] but not to those untoward happenings which are referable to the normal hazards of living.

These three main sections of the scheme (employment-, road traffic- and domestic- related funds) are financed by levies from employers, including the self-employed, motor vehicle owners, taxation and investment income,[114] employers being subject to substantial increases in charges,[115] although the administration costs amount to only 7% of turnover.[116] Accident prevention and rehabilitation are also aims of the scheme, although subsidiary to these main

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[113]In addition, sometimes foreseeable ones. See infra.

[114]See, Medical Negligence and No-Fault Compensation, A.F. Phillips, 1989 J.L.S.S. at p. 240 et seq.

[115]King's Fund study, supra, table 6, at p. 21: the proportional contribution from employers to the Corporation increased from 50.6% in 1986 to 71.2% in 1988.

[116]King's Fund study, supra, at p. 21.

goals. All "personal injury by accident"[117] attracts compensation from the appropriate fund.[118] As disease as such has not been included, the scheme is clearly not a needs-based one.

The scope of the threshold definition[119] for compensation has occasioned debate,[120] particularly in respect of "medical misadventure"[121] and, for example, heart attacks which, if work-related, have attracted compensation under the scheme.[122] Known adverse consequences of surgery have been held to constitute "medical misadventure",[123] though risks pertaining to the individual patient's

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[117]Section 2, (New Zealand) Accident Compensation Act 1974, as amended. See inter alia ch. 4, "Personal Injury by Accident", in Accident Compensation in New Zealand, A.P. Blair, second edition, Butterworths (New Zealand), 1983.

[118]See Medical Negligence: Compensation and Accountability, King's Fund Institute, C. Ham et al., 1988, at p. 21 et seq.

[119]What an "accident" is has also been considered, for example whether unlawful arrest or detention can constitute it: The Accident Compensation Act and damages claims (I), J. Miller, 1987 N.Z.L.J. 159.

[120]Personal Injury by Accident, K.L. Sandford, 1980 N.Z.L.J. 29.

[121]At p. 76, Accident Compensation in New Zealand, cit. sup.

[122]At p. 69 et seq., Accident Compensation in New Zealand, cit. sup.

[123]MacDonald v. Accident Compensation Corporation 1985 5 N.Z.A.R. 276 (bowel fistula following repair of ureter; known complication held to be "medical misadventure"); Accident Compensation Corporation v. Auckland Hospital Board 1980 2 N.Z.L.R. 748 (pregnancy following sterilisation operation).

(possibly idiosyncratic) physiology have been excluded.[124]

Once entitlement to compensation was established, an accident victim received up to 80%, index-linked, of his prior earnings, plus medical expenses and the possibility of a fixed sum including an element for pain and suffering.[125]

It is immediately evident that, although the scheme in practice includes all negligence, it is by no means free of criticism,[126] one which has been advanced being that, "[T]here is a belief that even now many people think that accident compensation is a form of "welfare" and not an earned right".[127] The qualifications surrounding the scope of "medical misadventure" require at least some degree of aetiological enquiry: arguably an uncertain scientific endeavour, expensive in skilled professional resources. Such enquiry also bears an uncomfortable similarity to the causal enquiry required in the present law, which we have

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[124]Viggars v. Accident Compensation Corporation 1986 6 N.Z.A.R. 235, in which a patient who had previously suffered strokes presented a risk outwith that normally expected during arteriography and accordingly was refused compensation.

[125]See Medical Negligence and No-Fault Compensation, A.F. Phillips, 1989 J.L.S.S. 239, at p. 240 et seq. and the King's Fund study (ibid.). Permanent impairment now attracts an inflation-eroded maximum of NZ$ 27,000 (Accident Compensation in New Zealand, E. Solender, 1992 J.L.S.S. 23, at p. 24).

[126]For example where prisoners injured themselves escaping from gaol: Accident Compensation in New Zealand, The Current Status, J. Cumming, 1992 J.L.S.S. at p. 24. See also, Damages for Personal Injury, N.J. MacKinnon, 1992 J.L.S.S. 21.

[127]Accident Compensation in New Zealand, E. Solender, supra, at p. 24.

already considered as presenting one of the most formidable barriers to an efficient and realistic system. Such schemes may also entail some enquiry as to the conduct of the doctor, in order to elucidate whether his professional intervention was likely to have caused the adverse consequence under consideration. This may mean an effective application of a standard of care, or reasonable foreseeability test, again strongly reminiscent of the present method of analysis in delict or tort. There has also been some consideration of whether a narrow interpretation of "medical misadventure" was sufficient to exclude the possibility of a tort action by the patient.[128]

It may be observed generally that fundamentally the only way to avoid all causal (and also medical conduct-related) enquiry is to compensate all according solely to their need, without regard for the aetiology of disease or disability. To do so, however, poses essentially political questions[129] of the level of resources which are committed to compensation as compared with competing priorities.

Indeed, it must be noted that the Accident Compensation Scheme has experienced some difficulties in funding its existing programme.[130] Thus for the three years between 1985 and 1987, expenditure exceeded income and

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[128]Medical Practitioners' Liability for Personal Injury Caused by Negligence, C.R. Cripps, 1978 N.Z.L.J. 83.

[129]Which are outwith the scope of this thesis.

[130]See the King's Fund study, op. cit., at p. 22 et seq..

required to be met from reserves.[131] Over a thirteen year period (1975 - 1988) increases in expenditure exceeded those in income almost threefold.[132] Although at one stage the levy upon employers (including the self-employed) was reduced, it was subsequently increased enormously, by a factor of 300%, in order to allow annual income to exceed annual expenditure.[133] Until the recent proposed changes considered below, these financial difficulties were not thought sufficient to justify radical change to an apparently otherwise popular and successful scheme.[134]

Many other criticisms of the scheme have been made. These include the possibility of abuse,[135] i.e. of unfounded claims, distortions in compensation coverage where an accident victim will obtain compensation for a condition which, if it occurred naturally, would remain uncompensated. Criticism of reduced incentives amongst doctors to maintain or enhance their standard of practice has also been made.[136] However, against this it may be argued that compensation levels have hitherto been relatively generous: as has been seen, up to eighty per

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[131]King's Fund study, op. cit., at p. 22, Table 7.

[132]King's Fund study, op. cit., at p. 22.

[133]King's Fund study, op. cit., at p. 22.

[134]King's Fund study, op. cit., at p. 22 et seq.

[135]See supra.

[136]See the King's Fund study, op. cit., at p. 22 et seq.

cent of pre-accident earnings have been payable, plus medical expenses and separate lump-sum payments for permanent disability (and in respect of the equivalent of solatium[137]). As already adverted to, some resources enhancing rehabilitation, and a body concerned to reduce the levels of accidents,[138] are non-pecuniary forms of the broader view of compensation which a non-tort scheme such as this is able to provide. For the victim of a negligent medical accident, the scheme is much more likely to provide compensation than hitherto, but even with such a broad-reaching ethos this is not necessarily automatic or free from aetiological enquiry.

At the time of writing, it seems that far-reaching changes will engulf the health service in New Zealand and also the accident compensation scheme. It is expected that those who suffer medical accident will no longer be provided with free medical treatment, but will, surprisingly, be dealt with as if ill by chance and de novo, for which payment in respect of treatment costs will now be required:[139]

> "[M]ajor changes were also announced in New Zealand's widely admired "no-fault" compensation scheme....Gone too are the lump-sum payments for permanent injury, without any restitution of the right to sue. The administrative costs of the

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[137]See Medical Negligence and No-Fault Compensation: Background to the Current Debate, A.F. Phillips, op. cit.

[138]Although this does not include medical accidents.

[139]"New Zealand: Health System Reforms", Sandra Coney, 1991 The Lancet, at pp. 374 - 375.

> new system are predicted to be immense, and the Government agrees that these may offset any revenue gains. In fact, the charges seem to be more ideological than revenue-earning. The Minister of Health, Simon Upton, and other MPs believe that having to pay will make people more aware of the cost of services and therefore less likely to malinger....
> "The most radical feature of the changes is a provision enabling people to take their share of health funding and leave the public health system. They can then buy into private health-care plans that will be required to provide for all their health-care needs."[140]

It is anticipated that four very large regional health authorities will be the only health-care funders, although not providers of services, and charges will be made for health-care if an individual's income exceeds NZ$ 332 per week - approximately equivalent to £10,000 per annum at the time of writing.[141] It has also been reported that New Zealand doctors will in future have to pay a levy (£150 per annum) to fund statutory compensation for medical misadventure, although only for those patients experiencing serious, and relatively rare, iatrogenic complications.[142] These changes call into question the philosophy of the accident compensation scheme, and it remains to seen whether its funding is sustained, or if it will fall into decay.

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[140]"New Zealand: Health System Reforms", by Sandra Coney, op. cit. at p. 374.

[141]"New Zealand: Health System Reforms", Sandra Coney, op. cit., at pp. 374 - 375.

[142]New Zealand doctors must pay for medical misadventure, R. Paterson, 1992 B.M.J. 1203, at p. 1203.

Sweden

The Patient Insurance Scheme in Sweden is restricted only to medical accidents, although a separate scheme for pharmaceutically-caused harm was introduced three years subsequently in 1978.[143] Finland has recently introduced a similar scheme in respect of medically-caused injuries. Although there are discrete schemes in Sweden for employment-related and road-traffic injuries, these are, in total and individually, of much lesser scope than the New Zealand approach.[144]

The Swedish system is essentially mixed, and it must be borne in mind that a more generous social security system exists in that country compared with Britain. A relatively high threshold level of social security benefits means that the cost of providing additional compensation by the no-fault scheme, up to a reasonable level, is relatively low. An option exists for patients to sue under the Swedish tort system if they do not wish to avail themselves of the automatic but lower compensation available under the no-fault scheme. Although this might be criticised as entailing all the expense of running two systems where one would suffice (unlike the New Zealand

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[143]See generally, The Swedish "No-Fault" Compensation System for Medical Injuries - Part I, M. Brahams, 1988 N.L.J. 14.

[144]See the King's Fund study, supra, at p. 23 et seq.

scheme, which involved far more extensive effective reduction in the availability of tort remedies) the Swedish Patient Insurance Scheme is limited in scope, and patients appear to have little incentive to have recourse to litigation as the benefits approximate to those in tort.[145] It is relatively inexpensive to offer the tort option, compared with what this would otherwise entail in a wider scheme of accident compensation. It is also notable that the Swedish approach has not been subject to the same financial strictures as has been the case in New Zealand. The Patient Insurance Scheme is run by a consortium of insurance corporations, but largely funded by the county councils. These pay a small sum (70 pence[146]) by way of levy in respect of each individual resident within their jurisdiction. The same heads of compensation are covered as in New Zealand, comprising loss of income, permanent disability or impairment, the cost of medical treatment and a sum representing solatium.[147] The average cost of an "accepted claim"[148] in 1987 was £3,200; approximately half of claims submitted are settled.[149] Relatively minor, self-

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[145]King's Fund study, op. cit., at p. 24.

[146]1987 figures: see the King's Fund study, op. cit., at p. 23.

[147]See Medical Negligence and No-Fault Compensation, A.F. Phillips, 1989 J.L.S.S. 239, at p. 241.

[148]See the King's Fund study, op. cit., at p. 23.

[149]See the King's Fund study, op. cit., at p. 23.

inflicted and naturally-occurring diseases or injuries are excluded from the scope of the scheme. Once again, so far as medical matters are concerned, the scheme compensates more than simply medical negligence; its Medical Responsibility Boards also assess and improve the standard of care.[150] In addition to purely accidental, i.e. non-negligent, medical injuries, separate categories cover all stages of the patient's contact with the doctor.[151] These in effect include negligent delicts both of omission and commission. Thus, diagnostic injuries are included, which may result from invasive diagnostic procedures. As one would logically expect, mis-diagnosis is also included as a separate, if related, category. Treatment injuries which are avoidable (which suggests some form of test for the standard of care not dissimilar from the present one) are compensated under a discrete category, as are infection and so-called accidental, commonly physical or mechanical, injuries. A major exclusion from the scheme is any condition arising from the provision of emergency treatment. Again, generally speaking, if any infection or complication is a normal or unavoidable hazard of the underlying condition, it will not be compensable.

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[150]Dealing with Medical Malpractice: The British and Swedish Experience, M.M. Rosenthal, Tavistock, 1987, at p.184 et seq.

[151]See, Compensation for personal injuries - the Swedish patient and pharmaceutical insurance, C. Oldertz, at p. 20 et seq.; ch. 2 in No Fault Compensation in Medicine, ed. R.D. Mann, J. Havard, Royal Society of Medicine, 1989.

We may see from these that there are elements reminiscent of the test for medical negligence in these categories, in addition to a need for causal enquiry as to the provenance of the condition. The Swedish Medical Responsibility Boards and those hospital boards concerned with the administration of the scheme also have a positive role in deterring and educating the profession away from repetition of avoidable untoward consequences, whether negligent or not, and toward a higher standard of professional care. It is submitted that it is difficult to view such an approach as other than an eminently sensible balance between coercive and educative preventive measures, and one that should be incorporated within United Kingdom medical practice.[152] It may also be commented that, paradoxically because of the scheme's relatively limited scope, some aetiological difficulties will be elided in view of the fact that some medical involvement by the patient with his own doctor or a hospital is a precondition of eligibility. This at least presents the decision-maker with the essential information of the patient's previous condition and provides details of the treatment or approach employed which led to the claim. It also concentrates decision-making in the hands of those arguably best qualified to assess such matters: the medical profession itself. However, the option to sue in tort is likely to

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[152]This will be considered further in the writer's proposals for reform.

set a limit upon any desire of the profession to be unduly lenient in the matter of self-criticism.

The United Kingdom

It is interesting to note that, despite the unwillingness of the Government of the United Kingdom to countenance a medical no-fault compensation scheme, the British Medical Association has recently supported the introduction of a no-fault scheme, establishing a working party to consider the issue and to make recommendations.[153] It has been commented that this is not solely because of the well-documented recent increases in the cost of claims settlement,[154] but also because of delays and the inherent nature of the adversarial system of medical negligence litigation.[155]

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[153]Compensating for Medical Mishaps - A Model "No-Fault" Scheme, D. Bolt, 1989 N.L.J. 109.

[154]Reliable figures on the underlying incidence of claims are, in effect, non-existent. However, the well-documented increase in the expense of damages awards in cases of medical negligence may perhaps be ascribed partly to more invasive neo-natal procedures, and general inflationary trends in the economy. Substantiating this directly is difficult; see, however, Escalation of Damages for Medical Negligence, L. Anderson, 1988 (Winter) Journal of the Medical Defence Union 56, and Damages for Personal Injuries and Death, J. Munkman, eighth edition, Butterworths, 1989, p. 196 et seq.

[155]See No fault compensation - the B.M.A. proposals, D. Bolt, chapter 6 in No Fault Compensation in Medicine, ed. R.D. Mann and J. Havard, Royal Society of Medicine Services Ltd., 1989. David Bolt chaired the working party which considerd and recommended the no-fault scheme proposed by the B.M.A.

The insurance-based proposals are essentially similar to the Swedish scheme. Seven guidelines have been suggested, as follows:

(1) physical injury only is compensable;

(2) natural progression of disease is non-compensable;

(3) "reasonable" diagnostic error is non-compensable;

(4) unavoidable complications are non-compensable;

(5) post-operative infection is compensable;

(6) pharmaceutical complications are excluded, and

(7) "extraneous" accidental injuries would be compensated.[156]

As this summary implies, the authors of this proposal considered that, "[S]adly, it is evident that all medical mishaps cannot be compensated. The cost would be prohibitive, even if Government finance was freely available."[157]

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[156]No fault compensation - the B.M.A. proposals, D. Bolt, op. cit., at p. 95.

[157]No fault compensation - the B.M.A. proposals, D. Bolt, op. cit., at p. 94.

Some expansion of these seven principles is valuable.[158] The B.M.A.'s working party reluctantly decided that if non-physical injury, i.e. including psychological trauma consequent upon negligence, were compensable then any such scheme would be swamped with substantial claims. This would imperil its financial viability. Instead, compensation would be limited to the reimbursement of identifiable financial loss following injury, subject to restrictions similar to the Swedish scheme in respect of the first thirty days' illness.[159] Other limitations, comprising both deductions of benefits paid from other sources and an upper limit on compensation of, say, twice the national average wage, would also be required.[160]

The exclusion of losses caused by the natural progression of disease or infection, by unavoidable complications and in respect of "reasonable" diagnostic error clearly require the application in effect of a standard of reasonable care and some aetiological enquiry. Such requirements are thus open to some of the criticisms which we have made of the present law, although they are likely to represent a substantial amelioration of it

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[158]No fault compensation - the B.M.A. proposals, D. Bolt, op. cit., at p. 95.

[159]This is to exclude minor injury and hence reduce expense and administration. See No fault compensation - the B.M.A. proposals, D. Bolt, op. cit., at p. 95.

[160]See No fault compensation - the B.M.A. proposals, D. Bolt, op. cit., at p. 96.

nevertheless. The working party accepted that exclusion of pharmaceutical injuries was necessary to render the scheme practicable, but that a parallel scheme in respect of these was highly desirable and therefore recommended. This aspect has now been somewhat overtaken by events, inasmuch as new E.C. strict product-liability laws have been introduced. The proposed B.M.A. scheme places much emphasis upon the rapid evaluation and settlement of claims, in contrast to the prevailing litigation system.

More generally, these proposals emphasized other germane issues. Procedural (in the sense of non-substantive) aspects of the present action for damages for medical negligence did not escape criticism. It was commented, from a medical perspective, that

> "[I]t is inevitable that, as compensation depends upon the proof of negligence on the part of those responsible for patient care, any attempt by the victim to secure recompense will be strenuously resisted, as no professional person is happy to be found guilty of negligence in relation to the care given to the person for whom he is responsible. Consequently, at the first suggestion that litigation is being considered, the normal relationship between doctor and patient is destroyed and replaced by an adversarial situation, totally foreign to everything for which the profession stands."[161]

This view is presumably based both upon the doctor's professional ethic and that trust which must exist between doctor and patient. This trust may well be to a deeper and greater degree than is the case, for example, between

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[161]No fault compensation - the B.M.A. proposals, D. Bolt, op. cit. at p. 93.

solicitor and client, since the medical relationship is peculiarly and intensely personal. It may require the disclosure of highly personal and worrisome or embarrassing information. Given the ethos of the healing profession, it seems inappropriate that a further and deeper souring of that professional relationship is occasioned by the adversarial nature of the claims process; it has been said that often the injured patient in fact seeks an explanation of, and perhaps apology for, his or her mishap.[162] Certainly this seems plausible, at the least in the case of relatively minor accidental or negligent medical injury. If this is so, it is difficult to conceive of a better mechanism for preventing explanations than the adversarial pre-litigation manoeuvres. On balance, the writer therefore entertains serious doubts about the appropriateness of adversarial-type litigation in the context of medical negligence.

The funding of the B.M.A. proposals was suggested to be substantially by means of savings from the anticipated reduction in use of the tort or delict action, although the option for a patient to sue would again be retained. However, the extreme difficulties of, and lack of appropriate data in considering, the estimates of funding

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[162]See, for example, p. 10, No fault compensation - a discussion paper, R.D. Mann, chapter 1 in No Fault Compensation in Medicine, op. cit.

were acknowledged.[163] Nevertheless, it has been pointed out that, prior to the recent change in the funding of claims of Crown indemnity,[164]

> "..the profession puts of the order of ninety million pounds a year into indemnity insurance, of which less than 50% actually reaches damaged patients. Evidently, there is a substantial margin for improvement in the application of the profession's money, if the element of litigation could be reduced in favour of providing help in a non-adversarial manner for those with real need."[165]

It might, however, be argued that the introduction of the Crown indemnity scheme has changed matters. This scheme covers National Health Service hospital and directly-contracted community doctors and dentists, and provides indemnity by health boards or authorities for liability for negligence within the scope of the doctor's or dentist's contract of employment within the health service.[166] General practitioners, who are independent contractors to the health service, do not come within the scheme, and all

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[163]No fault compensation - the B.M.A. proposals, D. Bolt, op. cit. at pp. 96-97. A pilot study and a full actuarial evaluation on behalf of defence organisations and health boards and authorities was urged.

[164]See, inter alia, Medical Negligence and No-Fault Compensation: Background to the Current Debate, A. Phillips, supra, and Scottish Home and Health Department N.H.S. Circular 1989 (PCS) 32: Medical Negligence: New Arrangements for N.H.S. hospital and community health service doctors and dentists, and Circular (December 1989) to all District and Regional Health Authorities advising of the introduction of Crown indemnity for N.H.S. hospital doctors and dentists.

[165]No fault compensation - the B.M.A. proposals, D. Bolt, op. cit., at p. 97.

[166]See M.D.D.U.S. News, December 1989, "N.H.S. Indemnity".

private or "good samaritan" treatment is, of course, also excluded.[167] The reason for the introduction of Crown indemnity was acute Governmental and professional concern over the rapidly-increasing cost of medical indemnity insurance, despite the considerable contributions made to doctor's premium payments by health boards and authorities.[168] This particular problem only was solved, because instead of requiring insurance in order to practise in health service hospitals, the employer effectively provided insurance at no cost to the individual doctor. As Crown bodies, however, health boards and authorities do not insure and thus carry the burden of payment of damages themselves, to the potential detriment of patient-care budgets in these cost-conscious times.[169] N.H.S. hospitals which have opted out of health board or authority financial control are liable for the costs of negligence claims made against them.[170]

However, the adoption of Crown indemnity does not necessarily imply any reduction in the total amount of compensation paid to patients, although any new trends in the response by health boards and authorities to claims remain to be seen. Furthermore, two fundamental potential

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[167]See M.D.D.U.S. News, supra.

[168]See Medical Negligence and No-Fault Compensation: Background to the Current Debate, A. Phillips, cit. sup.

[169]Supra

[170]See ch. 2, supra.

difficulties remain. Even though the concern at substantial increases in the cost of indemnity insurance has now been allayed, this is arguably treating the symptoms rather than the underlying cause. Thus, the substantive law remains unchanged, and there is no reason to suppose that the trend of increasing costs of settlement or defence, leaving aside the elusive increase or decrease of negligence per unit head of patient population, will diminish. The second factor is the more obvious one that health boards and authorities henceforth will require to meet a potentially very much larger proportion of the costs of negligence from their own budgets, without sharing these with the medical defence organisations. It is therefore arguable that an acute increase in costs associated with medical negligence may recur in the future. The introduction of Crown indemnity in the National Health Service represents more a re-allocation of existing costs rather than their reduction; the broad issue of no-fault compensation is thus still a relevant one.

No-Fault Compensation: Conclusions

No-fault compensation schemes have many attractive features, but they are not a panacea. Quite apart from the politico-economic doubts now attaching to the New Zealand system, unless a compensation scheme is wholly comprehensive it is impossible to eliminate the difficulties inherent in aetiological enquiry and forensic examination of the standard of care even though these may be attenuated.

It is thought that if a no-fault scheme can be justified, it would in ideal circumstances be viewed as a first step towards a comprehensive needs-based compensation scheme. This would compensate all those with a given condition equally, irrespective of how it arose, and would therefore wholly eliminate troublesome causal[171] and conduct-based enquiries. Such an approach would by no means be beyond possible criticism: the effects of lower deterrence on actual standards of care or on the perception of individual responsibility would require to be considered, although it might be felt that the other benefits such a system would bring were worth the sacrifice of these. Greater aid in rehabilitation and accident or negligence prevention might be a wider part of a broadly-

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[171]Compensating Victims of Disease, J. Stapleton, 1985 5 Oxford J. Legal Studies 248, at pp. 250-252.

based system, as in New Zealand, reflecting the then prevalent aims. This will be further considered infra in the context of the writer's proposals for reform.

Needs-Based Reform

The broadest and most extreme potential reform in the spectrum which we are considering is so-called needs-based reform. As its name implies, reform of this type is preoccupied with the issue of compensation. For our purposes, it therefore contributes little to the non-compensatory objectives: it compensates victims of medical negligence simply and solely as individuals evincing need. Furthermore, as it refers to the far wider questions of the scope and levels of compensation in society, which it is suggested are ultimately for elected representatives to determine, discussion will only be to the limited extent that they are relevant to reform of the law of medical negligence. Essentially, needs-based compensation refers to a conceptual category of very broad application rather than to specific theories and precepts of compensation. The work of Stapleton[172] is a major support of the principles and rationality[173] of such an approach, although

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[172]See Disease and the Compensation Debate, J. Stapleton, Clarendon Press, Oxford, 1986.

[173]Cf. Principle and Pragmatism in the Compensation Debate, K. S. Abraham, 1987 7 Oxford J. Legal Studies 302 at pp. 306-308.

a recent empirical study has provided evidence of distortions in the tort and social security systems which found the recommendation that "..the future policy-maker should plan to phase out all existing compensation systems which favour accident victims (or any category of them) over illness victims."[174]

The driving force behind the arguments in favour of needs-based compensation is that the tort (and also social security) system provides varying degrees of support for accident, disease and other victims, for which no rational justification may ultimately be advanced. These variations and distortions are therefore not acceptable, and equality of treatment should be instituted. However, it has been said that

> "[V]ictims of accidents and illness in England and Wales receive compensation and support from a multitude of poorly co-ordinated sources, with widely varying criteria of entitlement. The supposed goals and effectiveness of these various systems have been extensively debated amongst lawyers, economists, and those concerned with social policy. In particular, the tort (damages) system, whereby accident victims may sue for damages on grounds of fault, has come under widespread criticism as costly, inefficient, and inequitable in practice. The total abolition of the tort action in personal injury cases has been seriously proposed."[175]

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[174]Compensation and Support for Illness and Injury, D. Harris et al., Clarendon Press, Oxford, 1984, at p. 327.

[175]Preface to Compensation and Support for Illness and Injury, D. Harris et al., Oxford Socio-Legal Studies, Clarendon Press, Oxford, 1984. See also Disease and the Compensation Debate, J. Stapleton, Clarendon Press, Oxford, 1986.

Clearly, this is a fundamental criticism which must be taken seriously by all concerned in the quest for a more rational and just system of delict or tort, as well as those whose interests extend even further afield. The provenance of the present system may be largely explained, even though not justified, by the operation of the political system and the principle of scarce resources, which all those in favour of widely-based compensation schemes must ultimately consider.[176]

Thus, the needs-based reform movement aims to substitute these arguably arbitrary preferences of the present system in favour of a uniform scheme embodying equality to the greatest extent possible. This in turn involves a change in ethos of substantial degree, to the effect that the non-compensation aims of delict and tort (and of the current social security system) are altered or reduced, in favour of general community responsibility for hazardous activities.[177] For example, little allowance is usually made in respect of the deterrence, and policing of individual responsibility, claimed for tort and delict.

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[176]Writing by the so-called "tort lawyers", in favour of retaining tort and delict, includes, for example, New Zealand's Accident Compensation Scheme: A Tort Lawyer's Perspective, L. N. Klar, [1983] 33 University of Toronto Law Journal 80; The Advantages of Fault, W. W. McBryde, 1975 J. R. 32, and Principle and Pragmatism in the Compensation Debate, K. S. Abraham, 1987 7 Oxford J. Legal Studies 302.

[177]Medical Negligence and No-Fault Liability, C. Clothier, cit. sup.

However, one important criticism of needs-based compensation is not merely the likely expense involved in compensating all who demonstrate need, probably from one central fund, but where the boundaries are to be set. In other words, if all illness and disability is to be compensated, how are these to be defined and delimited? Would illness extend to all medical conditions, including trivial ones? Would self-inflicted conditions, perhaps related to alcohol or tobacco consumption be included? Would a genetic predisposition to excess alcohol or tobacco consumption be compensable? How would stress-related work illnesses, which have caused difficulties in the New Zealand scheme, be treated? Would "disability" extend generally to hereditary conditions or diseases? Would it apply to psychological conditions or diseases, or to a person's cosmetic appearance, intelligence and abilities? Although these are perhaps extreme examples, it is submitted that there would be a real risk of difficulties of scope arising.

The arguments against preference appear to arise as a converse of the absence of justification of existing preferences and discrimination. Thus, Stapleton's category of man-made disease victims are discriminated against in favour of conventional, acute-accident and trauma victims.[178] Man-made disease victims are argued to be

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[178]This is to oversimplify grossly; unfortunately, dictates of space and scope prevent a full consideration of the theory. See Disease and the Compensation Debate, op. cit., and per contra

effectively disenfranchised both as to proof of fault, because of long-latency and lack of aetiological knowledge, and because of even greater difficulties of proof of causation.[179] Even if we accept that the argument against preference is valid in principle and that exceptions may not be made, three points arise in the context of medical negligence.

Firstly, the accident preference criticised by Stapleton[180] and others[181] probably does not extend to those who suffer loss by medical negligence. As we have seen, there is evidence suggesting that such claimants are disadvantaged compared with their peers.[182] Secondly and relatedly, if medical negligence victims are indeed discriminated against under the present law, then to

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Principle and Pragmatism in the Compensation Debate, K.S. Abraham, 1987 7 Oxford J. Legal Studies 302, which criticises Stapleton's thesis inter alia that man-made disease victims are not shown to be a numerically significant category, that scientific knowledge is ever-advancing and thus decreasing the aetiological "knowledge gap" and that Stapleton's advocation of needs-based compensation is not made out, in competition with the non-compensation aims of tort.

[179]Partly as a result of the operation of the balance of probabilities test. See Disease and the Compensation Debate, op. cit., chapters 3 and 4.

[180]Disease and the Compensation Debate, op. cit., especially chapters 1 and 2.

[181]Atiyah's Accidents, Compensation and the Law, op. cit., at p. 552 et seq.; Compensation and Support for Illness and Injury, D. Harris et al., op. cit., at p. 2 et seq. and p. 317 et seq.

[182]Pearson Report, op. cit., vol. 2, p. 67, para. 242; vol.2, Table 11, p. 19 (discussed supra); King's Fund study, ibid.

implement measures designed to restore this to the level of benefits[183] enjoyed by other categories of tort or delict damages claimants is neither to institute nor to approve a preference, but rather to rectify a pre-existing "balance of injustice" which delict and tort do not yet formally acknowledge. This need not infringe an injunction against preferential treatment, even within negligence litigation. This may be considered in the context that different jurisdictions and perhaps also intra-jurisdictional areas may display markedly varying claims incidences:

> "[C]anadian physicians are only one fifth as likely to be sued for malpractice as their American counterparts. We believe that this remarkable difference is attributable to a number of legal and institutional factors in Canada, including the presence of universal health insurance, more generous programs of social welfare, limited use of contingency fees, the practice of having the losing party bear the costs of litigation, limited awards for pain and suffering, infrequent use of juries, the effective defense work of the C.M.P.A. [Canadian Medical Protective Association], and a less litigious culture."[184]

Thirdly, the pragmatic argument applies that, perhaps in order to rectify a previously inequitable system, a limited no-fault scheme, say, might be instituted. This might also be seen as a first step toward a fully comprehensive compensation reform, or as a long-term restoration of equality in itself.

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[183]Including non-compensatory ones.

[184]Medical Malpractice - The Canadian Experience, P.C. Coyte, D.N. Dewees, M.J. Trebilcock, 1991 The New England Journal of Medicine 89 at p. 93.

Furthermore, the arguments of those who advocate needs-based reform are based mainly upon the needs of the pursuer or plaintiff. An argument may equally be advanced that the needs of a medical defender also require consideration: that an episode of negligence in which harm happens to have resulted should perhaps not be accorded such prominence, as this may minimise or disregard its perpetrator's previously good practice and successful treatment results. However, it is suggested that there may also be a risk that the medical profession has allowed or encouraged public expectations of medical treatment to become too high, and that this has contributed to the increasing costs of claims in respect of medical negligence.

One method of easing the pursuer's path to compensation for medical negligence would be to reverse the onus of proof, or to introduce strict liability. The advantage of both of these possibilities is that they entail relatively little change to the present law. Such reforms would carry risks, however; the doctor would in effect be guilty until proven otherwise. This might encourage a flood of unsubstantiated claims, and if the tactical burden were placed during litigation upon the pursuer, as would be likely, he or she might not be significantly better off than at present. Such a reform would run the risk of replacing injustice to the pursuer with injustice to the defender. In the view of the writer,

the demerits associated with these possible changes outweigh their benefits. Furthermore, the existing difficulties of delay and the use of procedural technicalities would be unchanged. This suggests that a reform tailored to the specific characteristics of medical negligence is required.

Despite its attractions, the broadly-based New Zealand system of accident compensation represents an unsatisfactory compromise. It has been the widest scheme for non-fault compensation available anywhere, but even so has been subject to financial difficulties and now appears to be at risk of being substantially changed or even dismantled. Furthermore, its treatment of medical accidents has not removed restrictions and difficulties in its scope. Some examination of causation is still required, as is some assessment of the reasonableness of the standard of patient-care. Certain conditions, such as employment-related heart disease, have occasioned especial difficulty. As far as medical negligence is concerned, significant reservations attach to the Accident Compensation Scheme so far as sufferers from iatrogenic injury are concerned. It would clearly require an even wider and more expensive scheme to provide compensation equally to all, with troublesome forensic enquiry eliminated. Similar doubts apply in the case of the otherwise successful Swedish scheme. It bears the twin disadvantages that, arguably, it perpetuates idiosyncracies

and distortions in the sphere of compensation - whilst again needing de facto evaluation of the standard of medical care and the aetiology of the condition. It must therefore be viewed as a pragmatic solution to the problems of medical negligence litigation, rather than one which is entirely satisfactory in principle. It is interesting to recall that the B.M.A.'s proposed scheme is closely based upon the Swedish model. The converse of this argument on pragmatism is that the judgment of medical and scientific issues is in the hands of medical personnel, without requiring the full panoply of the law - which itself would then require the detailed education and guidance of judges and lawyers as to technical medical matters. Arguably, the medical profession is where such decision-making should be located, and its use minimises the expense of judicial assessment of negligence and its incidents.

However, anything less than a wholly needs-based compensation system, of necessarily massive expense, must ultimately confront the inescapable point made in Atiyah's seminal analysis of tort reform, that

> "[T]he only way of eliminating causal issues entirely is to base entitlement solely and entirely on the need of the plaintiff for compensation. At present, not even the most extensive no-fault scheme in operation (that in New Zealand) compensates entirely regardless of cause."[185]

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[185]Atiyah's Accidents, Compensation and the Law, op. cit., at p. 548.

This, of course, applies equally to the question of establishing fault. Leaving aside the non-compensation aims of the law, it is clear that any less-extensive approach than this would be unlikely to avoid retaining some inequalities and pragmatism;[186] this is likely in practice to be unavoidable. It might, however, partly be justified on the grounds of rectifying a historical inequity, or as a first step towards comprehensive reform.[187] Unfortunately, irrespective of the principles supporting the broader forms of compensation, it must also be recognised that,

> "[N]evertheless the argument based upon cost is a potent political weapon available against the introduction of comprehensive compensation schemes covering illness and disease as well as accidents. Opposition to the abolition of tort rights tends to be bought off by providing generous benefits, but when applied to the sphere of disease as well as accidents, the high benefits generate new opposition because they make the scheme very expensive. Thus it can be seen that the shape of reform can be influenced as much by political pressures as by rational arguments of principle or policy."[188]

With these conflicting pressures in mind, it may be that the best which may realistically be attained is to accept

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[186]See, inter alia, Dealing with Medical Malpractice: The British and Swedish Experience, M.M. Rosenthal, Tavistock, 1987, especially chapters 9-16.

[187]"If partial abolition of tort can achieve improvements....one can be confident that its total abolition improves matters even more." Atiyah's Accidents, Compensation and the Law, op. cit., at pp. 568-569.

[188]Atiyah's Accidents, Compensation and the Law, op. cit., at p. 554 (footnote omitted).

that, mutatis mutandis,

> "[E]ven if all we can realistically hope for is that the funds currently tied up in the tort system as it now operates will be better used, this is enough to justify a limited reform, even at the cost of creating or perpetuating anomalies between road accident victims and other social welfare recipients."[189]

This chapter has attempted to consider the various options for reform, some of which have been adopted in certain jurisdictions. The writer's submission is that none of these main schemes in itself is able to provide a suitable mechanism for combining the goals of compensation, deterrence and accountability. It is accordingly necessary to consider the wider restrictions upon potential reform, which is done in the next chapter by considering the arguments raised in Disease and the Compensation Debate. In the light of this, the writer's proposals for reform are then further developed.

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[189]Atiyah's Accidents, Compensation and the Law, op. cit., at pp. 575-6.

Chapter VII

Reform: Restrictions and Proposals; Conclusion

In this chapter, the writer considers some of the wider implications of, and restrictions upon,[1] reform of the law of medical negligence which arise from the compensation debate.[2] This involves primarily the issues which have been raised by Stapleton in her book, "Disease and the Compensation Debate",[3] and provides a necessary counterpoint to further consideration of the present writer's suggestions for reform. As has been mentioned, these seek to embody what are thought to be the (desirable) aims of the existing law, but with the disadvantages of their current incarnations reduced so far as possible.[4] It is submitted that the deterrent function is often under-emphasized; this is unfortunate partly because, if it is defined broadly as a concern to raise the standard of care

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[1]See generally, Controlling the Costs of Medical Malpractice: An Argument for Strict Hospital Liability, B. Chapman, 1990 Osgoode Hall L. J. 523, drawing attention to a North American upward spiral in negligence costs and proposing a strict-liability approach to limit the trend.

[2]See also Medical Negligence and No-Fault Compensation, A.F. Phillips, supra.

[3]J. Stapleton, Clarendon Press, Oxford, 1986. See also Accident Compensation for New South Wales, A.M. Angelo, 1983 N.Z.L.J. 335.

[4]"But in its role of regulating conduct and deterring carelessness, tort law, while a useful instrument against intentional wrongdoing, is a weak one against other forms of anti-social behaviour." Can the Law of Torts Fulfil its Aims? D. Harris, 1990 14 N.Z.U.L.Rev. 113, at p. 113.

within the practice of medicine, its achievement may in the longer term reap the benefits of a lower incidence of claims. Such considerations have led the writer away from arguing in favour of the relatively popular option of a no-fault compensation system,[5] and instead towards a "composite" approach which seeks to satisfy the disparate aims of the law but not by the present combined vehicle of the delict/tort action. It has been cogently argued that the law of professional liability in tort is undergoing something of a retrenchment,[6] perhaps suggesting that actual reform of the law of medical negligence, unless prompted by financial considerations[7] (as with Crown indemnity), is relatively unlikely.[8] However, there is some continuing interest in general in no-fault schemes in other jurisdictions.[9]

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[5]See, Medicine and the Law: No Fault Compensation, D. Brahams, 1989 The Lancet 170.

[6]The Decline of Tort Liability for Professional Negligence, K.M. Stanton, 1991 Current Legal Problems 83. However, Stanton argues that this shift is primarily focussed upon the contractual remedy which is of course inappropriate in most cases of medical negligence. See also, Professional Negligence: Some Further Limiting Factors, R. O'Dair, 1992 55 M.L.R. 405.

[7]As has been argued in the case of the United States: Controlling Health Costs by Controlling Technology: A Private Contractual Approach, P.E. Kalb, 1990 99 Yale L. J. 1109.

[8]Cf. the developments discussed in, Liability in Tort for Transmission of A.I.D.S.: Some Lessons from Afar and the Prospects for the Future, R. O'Dair, 1990 Current Legal Problems 219.

[9]The Scope and Meaning of No-fault Liability in French Administrative Law, R. Errera, 1986 Current Legal Problems 157.

Logically, it is thought that the actual detection of non-harm causing negligence is the first requirement. This is associated with raising the standard of care. It is submitted that it is practicable to detect a large proportion of the incidence of negligence, although not all. One step towards achieving this aim would be by instituting a reporting system by patients of episodes which cause them concern. This might cover genuine (i.e. non-fault) accidents, negligence, and also unexpected outcomes and patient disappointment.[10] There is some evidence that about a quarter of adverse outcomes result from medical negligence;[11] this may suggest that there are many undetected negligent and non-negligent adverse outcomes. However, in addition to this, other systems would be needed. If this deterrence mechanism was supportive and educative, rather than being perceived as retributive or threatening, doctors might be encouraged to admit and discuss their mishaps - especially those where no harm was actually caused. If necessary, this quality audit would be conducted under conditions of informality and in circumstances in which no voluntary disclosure or self-

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[10]It is difficult to determine whether the apparent increase in the incidence of medical negligence claims is attributable to an underlying increase in negligent care, a proportionate increase because of increased consultations at the same level of negligence, greater detection, etc. See, A Health Authority's experience, R. Bowles, P. Jones, 1989 N.L.J. 119.

[11]See, The Epidemiology of Malpractice, R. Smith, 1990 B.M.J. 621.

censure could be used for disciplinary purposes or litigation. It is submitted that such non-harm episodes are as important as those which do cause harm, from the point of view of this hortatory function of the law, even if not, of course, in terms of compensation. This proposal would, it is thought, improve the coverage and effectiveness of the aims of the law. A further development would be the increased use of medical audit and quality control. These already exist in some areas of the National Health Service, and consist of peer review and audit of the exercise of clinical judgment.[12] A main objective in their proposed application would be to improve the quality of care. Currently, these are composed of groups of doctors, practising in the same discipline or sub-discipline, inter alia analysing the case records of patients and considering their findings:

> "[O]n the Medical Unit at the Queen Elizabeth Hospital we have held a regular audit for the past 18 months and have found it to be an enjoyable and worthwhile procedure. Audits are held weekly at lunchtime and involve five consultant physicians and their junior staff. Once a month all deaths occurring in the previous month are reviewed; in the other weeks a random selection of recently discharged patients is looked at. The reviewer audits notes of patients who have not been under his care. Obviously the number of cases reviewed at the "death" audit varies...but is usually about two for each consultant. At the other audit each consultant reviews three sets of notes, which means that each month the notes of approximately a quarter

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[12]See, inter alia, Medical Negligence: Compensation and Accountability (Briefing Paper 6), C. Ham et al., King's Fund Institute, at p. 16.

> of all discharged patients are reviewed. The meetings last one hour..."[13]

This relatively informal and expeditious procedure could, it is thought, be expanded relatively easily and inexpensively. It appears to be a potentially useful tool for raising the standard of care:

> "[M]edical audit apparently resulted in appreciable improvements in aspects of care such as clerking and record keeping. Analysis of the scores of the general audits has led to the introduction of agreed standards that can be objectively measured and are being used in a futher audit, and from the results of the audits of clinical management have been developed explicit guidelines, which are being further developed for criterion based audit."[14]

Medical audit is already used, and being aggressively developed,[15] in the litigious United States:[16] "[it] is now an accepted part of American hospital life...[I]t demands a rigorous quality asurance by the hospital..."[17] It is submitted that medical audit procedures could readily and

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[13]Medical Audits, D.A. Heath, M.J. Kendall, R. Hoffenberg, O.L. Wade, J.M. Bishop, 1980 14 J. Royal College of Physicians of London 200.

[14]From Abstract, in: What did audit achieve? Lessons from preliminary evaluation of a year's medical audit, J. Gabbay, M.C. McNicol, J. Spilby, S.C. Davies, A.J. Layton, 1990 B.M.J. 526, at p. 526.

[15]Law-Medicine Notes: Medical Peer Review of Physician Competence and Performance: Legal Immunity and the Antitrust Laws, W.J. Curran, 1987 316 New England Journal of Medicine 597.

[16]See, Litigation-Mania in England, Germany and the U.S.A.: Are We So Very Different? B.S. Markesinis, 1990 49 Cambridge L.J. 233, especially at p. 260 et seq.

[17]Audit Reviewed: Medical Audit in North America, W. Van't Hoff, 1985 19 J. Royal College of Physicians of London 53, at p. 53.

appropriately be incorporated in the proposed new scheme, both at the level of patient treatment and forming the basis for the suggested Medical Audit Board. It is envisaged that these could incorporate the present audits, in order to conserve resources even though this appears to be a resource-efficient approach. There is some evidence that audit has resulted in the detection and investigation of potentially delictual inconsistencies in clinical decision-making in obstetrics.[18]

Analysis of all patient-doctor transactions, however, is thought to be wholly impracticable and probably unnecessary;[19] it is submitted that if necessary a suitable statistical sampling method could be designed with sufficiently high confidence levels. Further, areas of high-risk practice could be identified and perhaps concentrated upon, as has to an extent already occurred with the disproportionate escalation in the cost of indemnity insurance for obstetric practitioners. All these possibilities echo an emphasis on accident prevention which

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[18]Inconsistencies in clinical decisions in obstetrics, J.F.R. Barrett, G.J. Jarvis, H.N. MacDonald, P.C. Buchan, S.N. Tyrrell, R.J. Lilford, 1990 The Lancet 549, at p. 550 et seq.

[19]Existing medical audit schemes seem to utilise random selection, although a random sample could, it is thought, be easily arranged. Audit Reviewed: Clinical Review; A form of Audit? W. Van't Hoff, 1981 15 J. Royal College of Physicians of London 63.

has been present in the New Zealand approach,[20] rather than the largely reactive present legal approach to regulation. In addition, it is thought that the establishment of a pro-active and re-active body, analogous to the Mental Welfare Commission,[21] or perhaps the Swedish Medical Responsibility Board,[22] would be indicated. Such a body would respond to and investigate a proportion of patient notifications, both in harm and non-harm cases. Additionally, it would have its own jurisdiction to investigate individual cases and procedures ex proprio motu, and to make appropriate recommendations for the improvement of future practice, non-specific to individual practitioners. Failure by a doctor to implement such a recommendation might in appropriate cases be a matter for disciplinary censure.

The composition of such a body would include members of the medical and legal professions, with a regular secondment of new members drawn from the practising and academic branches of the professions. It is conceded that many difficulties would require to be overcome in order to render such a system practicable. Although it is difficult

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[20]See, for example, Tort Reform in the Welfare State: The New Zealand Accident Compensation Act, R. Gaskins, [1980] 18 Osgoode Hall L. J. 238.

[21]See Mental Health: A Guide to the Law in Scotland, J. Blackie, H. Patrick, A. Paterson, Butterworths/Scottish Legal Education Trust, 1990, chapter 6.

[22]See Dealing with Medical Malpractice: The British and Swedish Approach, M. Rosenthal, Tavistock, 1987, chs. 9-15; see also, Medical Negligence and No-Fault Liability, C. Clothier, 1989 The Lancet 603.

to make projections of cost which are other than speculative, it is not thought that these would be insuperable. The proposed Board is discussed further infra. Generally, however,it may be commented that quality control "circles" exist already in the National Health Service,[23] and represent a limited re-deployment of existing resources. Sufficient supporting and administrative staff would be required; with modern computerised data processing facilities, it is thought that this need not be unduly costly.[24] Similar arguments apply in the case of a Medical Audit Board, perhaps to a lesser degree. However, such a body would be unlikely to be able to cover all specialties in all locations. A solution to this would be delegation to a local or specialist committee, whose primary response would be educative. However, in the case of a doctor persistently or repeatedly breaching acceptable standards, remedial and ultimately perhaps disciplinary, steps would be required. This would be consistent with the present trend towards maintenance of qualifications by refresher course and examination. Where necessary, professional sanctions through the General Medical Council, or even the

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[23]Medical Audit in General Medicine, D.A. Heath, 1981 15 J. Royal College of Physicians 197.

[24]The current financial climate in the National Health Service would appear to suggest otherwise. On the other hand, health boards and authorities have recently undertaken full responsibility for N.H.S. damages for hospital-based negligence, the overall effect of which remains to be seen. Additionally, the proposal might produce long-term benefits in terms of accident prevention.

criminal law, would of course continue to be available as at present. It would be necessary for a standard to be applied across all specialties and those para-medical activities included within the scheme. It is submitted that the content of this standard would vary according to the specialty, circumstances and level of training and qualification of doctor concerned, subject to a minimum standard applying to all. The standard actually applied would be entirely a matter for assessing doctors in the specialty concerned, whom it is submitted would be the correct judges of such a matter. Inasmuch as a general form of words to express an idea of such enormously wide application is required, it is suggested that the standard be expressed, not as a minimum requirement (although there would no doubt be a tendency to regress to this) but instead be stated to be at least "acceptable practice". This would raise the question, "acceptable to whom?", the acceptability being largely of the external, assessing peer. Although tempered by subjectivity, as indicated above, the test would essentially be an objective one. It is thought that this would not only maintain but ultimately improve the general standard of care.

The response of the medical profession itself to such a proposal would be an important factor. Whereas it might meet with hostility initially, if its primary aim were seen to be as the positive one of negligence or mishap avoidance, by educative and supportive measures, this would

resolve itself. Great care would require to be taken to ensure that any disagreements between medical colleagues would not be fuelled or amplified. Several possibilities exist to ameliorate such a possibility. On a broad brief, consideration would have to be given to preventing the patient from pursuing an action where matters were dealt with under the proposal.[25] Any election by the patient not to litigate would, of course, have to be made at the initial stage of reporting, or perhaps after a preliminary finding by the proposed Board.[26] It is thought that, freed of the threat of litigation, both explanations to the patient, and participation in the proposed system by doctors, would be greatly encouraged. As regards medical staff themselves, an alternative might be available if an individual doctor did not wish to participate directly. It is envisaged that this would involve reporting to the proposed Medical Review Board on all patient-notified episodes or mishaps, and a summary based on a small random sample of all other cases dealt with by that doctor. This could then be discussed with a more senior colleague, with a view to improving the standard of care; the identity of

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[25]The proposal emphasizes the quality of the medical treatment, but compensation will also be considered infra.

[26]The practical significance of this would, of course, primarily be in cases involving harm. If the proposed scheme were to co-exist with a delict/tort action option, patients' wishes as to explanation or suing would be amply catered for. Any election would require to be final, in order to avoid double jeopardy. This is a problem with existing complaints procedures.

this colleague could be decided, within limits, by the disclosing doctor. Again, this would involve re-deploying existing resources, the cost implications of which should, it is submitted, be containable.

Though the proposed system depends to some extent upon good faith, such reliance is ultimately unavoidable in any professional context in which there is, axiomatically, an ethic to put the interests of patient or client first. In any event, it is thought that most episodes of negligence would, whether they caused harm or not, be included in the reporting by the patient.[27] Even if full detection of negligent episodes were not achieved, a significant improvement would result. In addition, the attitude of the profession to negligence would be likely to alter. Rather than polarising doctors and patients into potential litigants, the proposed scheme would treat negligence as a problem largely capable of a solution, without the present incentives for hostility.

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[27]The disclosure scheme, and peer review, would of course be of much greater importance where laboratory procedures and tests were concerned. If, however, a mishap resulted in either harm or other deviation from the expected or likely patient outcome, it is likely that such latent or concealed mishaps would be brought to light in the course of the attending doctor's participation in the proposed scheme.

Compensatory Aspects

Earlier this century, the common law of delict and tort developed relatively slowly, in response to developments in society. In more recent years, however, that pace of change has accelerated rapidly.[28] It is more recently still that the laws of delict and tort have come under systematic criticism.[29] This is partly fuelled by some extensive and (relatively) recent damages claims, such as those in respect of asbestos and thalidomide.[30] It is probably fair to state that the concern following these, and similar large-scale disasters, has provided an important impetus

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[28]The reasons for this trend are beyond the scope of this work. It may be speculated that the increasing complexity of modern life has made a significant contribution. A further trend is the tendency to produce specialist sub-areas, such as the law of medical negligence. This is demonstrated by the books recently published in these area. A recent example is Medical Negligence, M. Powers and N. Harris, Butterworths, 1990.

[29]In certain areas, it has been supplanted by statutory schemes. These may be conceived as a response to public opinion, or reflect policy goals. See, for example, the Workmen's Compensation Acts 1897 and 1906, and the Vaccine Damage Payments Act 1979. Cf. In praise of tort, R. Smith, 1991 N.L.J. 308.

[30]See Disease and the Compensation Debate, J. Stapleton, Clarendon Press, Oxford, 1986, at p. 1. Many of these claims are of course in respect of what would now be termed product liability, a subject which is outwith the scope of the present work. The basis of the law in this area is in the Consumer Protection Act 1987: see Product Liability, A. Clark, Modern Legal Studies, Sweet and Maxwell, 1989.

for the compensation debate.[31] This debate has raised several fundamental issues in relation to compensation, the main elements of which are summarized below before the present writer's proposals are set out. The work of Stapleton and of the Harris study represent probably the strongest and most systematic criticisms of the present compensatory regime. For this reason, and the breadth of their discussions, theoretical in the case of Stapleton and empirical in the case of the Harris study, reference will primarily be made to these works.

The inception of the New Zealand accident compensation scheme, together with the concerns which had been voiced, elicited a response from the British government: the establishment of the Royal Commission on Civil Liability and Compensation for Personal Injury, chaired by Lord Pearson.[32] Its remit was to consider compensation for death and personal injury in respect of injuries sustained in the course of employment, use of motor vehicles, supply or use of goods and services, use of premises and generally where a remedy would come within the common law of negligence, or possibly strict liability.[33] Although its remit seems broad, in fact the Commission concentrated on accidents at

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[31]One result of this concern was that New Zealand introduced its Accident Compensation Scheme, following the Woodhouse Report in 1967.

[32]The Pearson Report, in three volumes (Cmnd. 7054-I, II and III), was presented to Parliament in 1978.

[33]Pearson Report, op. cit., vol. I, at p. 3.

work and road traffic related claims. Acknowledging some concern over tort, the Report's comment is:

> "[T]he existence of a substantial no-fault scheme for industrial accidents, and the significant body of opinion which has drawn attention to the adverse effects of the tort system in the field of accident prevention, prompt serious consideration of the abolition of the tort action as a means of providing compensation for work accidents."[34]

The Report, however, concluded firmly against a general policy of tort abolition.[35] Stapleton comments that,

> "[T]he espoused philosophy of Pearson was a shift from tort towards no-fault but because of its limited reading of its terms of reference it felt it could not consider a comprehensive scheme.....[I]n other words, despite espousing a needs basis and the goal of removing compensation anomalies between the disabled, the whole thrust of the report was to increase the anomalies and complexities by this ad hoc approach which at best delays reform and at worst entrenches preferences which will further impede reform."[36]

In relation to medical negligence, tort abolition was seriously argued by some of those whom the Pearson Commission consulted. Despite its findings and emphasis upon the difficulty of proving fault and causation, the Report concluded, however, that

> "...we did not find these arguments strong enough to justify making medical injuries a special case where tort liability would not apply, especially as we received much evidence from medical and

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[34]Pearson Report, vol. I, p. 193.

[35]Pearson Report, vol. I, pp. 72-73, 193-195.

[36]Disease and the Compensation Debate, cit. supra, at p. 110.

other witnesses which favoured the retention of tort."[37]

Some of the Commission's members, however, recorded that,

> "[S]ome of us found this was a difficult decision and thought the arguments were finely balanced. All of us appreciate that circumstances may change, and that our conclusions may have to be reviewed in future."[38]

However, some limited reforms were suggested, one of which led to the passing of the Vaccine Damage Payments Act 1979, a scheme which has since been described as "half-hearted".[39] [40]

If the interest in the compensation debate waned with the non-implementation of many of Pearson's specific recommendations, concern was soon to be revived. Although the primarily American economic theorists had long criticised tort,[41] others, such as Atiyah,[42] Stapleton[43] and

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[37]Pearson Report, vol. I, p. 73. See Pearson Report, vol. I, ch. 24, for consideration of the question of medical negligence.

[38]Pearson Report, vol. I, p. 291.

[39]Medicine, Patients and the Law, M. Brazier, Penguin, 1987, at p. 145.

[40]For a discussion of the Pearson Report's findings in the context of the modern law of medical negligence, see Medicine, Patients and the Law, M. Brazier, cit. supra, ch. 9.

[41]A leading example is the work of Calabresi. See principally, The Costs of Accidents, G. Calabresi, Yale University Press, 1970.

[42]See Atiyah's Accidents, Compensation and the Law, Peter Cane, Weidenfeld and Nicolson, fourth edition, 1987.

[43]Disease and the Compensation Debate, J. Stapleton, Clarendon Press, Oxford, 1986.

Harris et al.[44] have more recently mounted a barrage of criticism of tort,[45] a trend acknowledged by textbook writers.[46] [47] [48]

In its modern form, the attack on delict and tort is mounted both on principle and on practical grounds. One of the strongest exponents of the latter is represented in the study by Harris et al.,[49] and a leading example of the former is the work of Stapleton.[50] Against the reformers

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[44]Compensation and Support for Illness and Injury, D. Harris et al., Oxford Socio-Legal Studies, Clarendon Press, Oxford, 1984. This wide-ranging survey re-opens many of the Pearson Report issues. Its authors conclude in favour of the abolition of the current damages action in tort (and presumably delict); see inter alia ch. 12.

[45]For a recent survey of out-of-court settlements in actions for damages for personal injury, see Hard Bargaining, H. Genn, Clarendon Press, Oxford, 1987.

[46]An interesting comment is made in Clerk and Lindsell on Torts, sixteenth edition, Sweet and Maxwell, 1989, ch. 10, "Negligence" (R. Dias and A. Tettenborn): "Much of the trouble has stemmed from conceptualising "duty", "breach" and "remoteness" and the superimposition of needless terminological confusion through the indiscriminate use of technical jargon in different senses. As the law of negligence stands, there is an irreducible minimum of requirements of liability; and it was in order to avoid conceptualising that these were set out in non-technical language....If these are to be abolished, then negligence as a form of liability will have to be abolished too, and some other basis, perhaps automatic insurance, substituted in its place."

[47]See The Modern Law of Negligence, R. Buckley, Butterworths, 1988, especially ch. 20, "Reform?".

[48]See also generally on tort Salmond and Heuston on the Law of Torts, by Heuston and Buckley, nineteenth edition, Sweet and Maxwell, 1987.

[49]cit. sup.

[50]supra

are ranged the so-called "tort lawyers": for example, Klar[51] and Abraham.[52] These commentators represent the core of the debate.

Stapleton's argument commences by identifying a category of negligently-caused damage, for which she demonstrates serious barriers to recovery of tort damages. In turn, the fault principle, strict liability, no-fault systems and causation are analysed. The implications for the system of compensation, on a much broader canvas than the law of tort, are worked out. These arguments are considered because of their implications for the law of medical negligence.

The starting point of Stapleton's thesis is to be found in analysis of the categories of misfortune which befall people. Broadly, the taxonomy employed by her is in effect that of causation. One class, for which tort damages are not exigible, is that of natural disease. Another is that of accidents. Where legal fault, causation and proof coincide, these of course will permit the recovery of damages. The principal class which Stapleton identifies and emphasizes is that of man-made disease. This inhabits a partly overlapping zone between these other two categories. As its name implies, man-made disease does not necessarily arise by the same sudden trauma which gives

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[51] supra

[52] supra

rise to an accidental injury, be it negligently or otherwise. Nor, by definition, is it "natural" in origin. They are "...injuries traceable to a non-traumatic but man-made source which might, therefore, in principle give rise to a claim in tort"; the class of natural or innate disablement and disease includes "..many cases where there is in fact a man-made cause not yet proven or suspected."[53]

The next step in Stapleton's argument is the observation that whereas traumatic accidents usually occur at isolated and identifiable times and places, man-made disease differs. By contrast, it may demonstrate long-latency periods, uncertain or, more likely, unknown aetiology or very gradual onset: the causing conditions are not readily identifiable as occurring at a definite time and place. As they are man-made, some or all may therefore be thought "in principle"[54] to be tortiously caused and therefore appropriate for the award of damages. This, argues Stapleton, combined with the inherent difficulties of detection and proof for a tort action, means that there is a major defect, both in principle and in practice, in the coverage of the present law. "No figures exist on the number of tort claims made in relation to non-traumatic injury, but from reported cases and the

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[53]Disease and the Compensation Debate, op. cit., at p. 4.

[54]Disease and the Compensation Debate, op. cit., at p. 4.

literature it appears clear that very few such claims are made and for these the success rate is low."[55]

Stapleton goes on to show how these characteristics of man-made disease effectively constitute barriers to recovery in a tort action. These include difficulties relating to time. With long-latency or gradual onset, such conditions (some types of cancer are cited as an example) may manifest themselves long after the carcinogenic exposure has ceased. This, apart from (prescription and) limitation issues, may prevent a plaintiff even from tracing a tortfeasor, far less for the law to exert a deterrent effect.[56] It may also lead to difficulties in meeting the burden of proof of fault. This is because the standard of care may not be well-established or articulated at the time of exposure. More specifically, the court's analysis of the defendant's conduct, in terms both of "knowledge" and "response",[57] is hindered. As she comments, this is because the risk may well be insidious and concealed, rather than obvious, and its "appreciation depends on knowledge acquired through means other than common experience."[58] In addition, the fault issue requires

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[55]Disease and the Compensation debate, op. cit., at p. 13.

[56]See Neoclassical Difficulties: Tort Deterrence for Latent Injuries, W.L.F. Felstiner, P. Siegelman, 1989 Law and Policy 309.

[57]Disease and the Compensation Debate, op. cit., at pp. 60-87.

[58]Disease and the Compensation Debate, op. cit., at p. 61.

to be dealt with over a period of time, rather than at a single point.[59] Foreseeability[60] and response are discussed in detail,[61] and it is shown that for the court to engage in the necessary evaluations is extremely difficult. This is partly because of policy questions, and partly because of the inherent nature of man-made disease,[62] and the lack of reliable data.[63] Procedural difficulties, and the self-perpetuating paucity of case law in this area are also discussed.[64] It is the present writer's view that these arguments are made out sufficiently. An even greater difficulty confronts the plaintiff, in Stapleton's view, than establishing proof of fault:[65] establishing forensically the necessary causal link.

The argument on causation is, once again, closely related to the nature of the harm in question. As a result

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[59]Disease and the Compensation Debate, op. cit., at p. 61-62.

[60]Disease and the Compensation Debate, op. cit., at p. 65 et seq.

[61]Disease and the Compensation Debate, op. cit., at p. 68 et seq.

[62]supra

[63]An argument on breach of statutory duty may not be available for a plaintiff in a man-made disease claim, either. Once again, this is because of the intrinsic nature of such disease. Disease and the Compensation Debate, op. cit., at p. 78-79.

[64]Disease and the Compensation Debate, op. cit., for example at p. 86-87, and ch. 4 generally.

[65]Disease and the Compensation Debate, op. cit., especially ch. 4, "Causation in Fact".

of its insidious nature, damage may occur in indirect, subtle but nevertheless serious ways. Examples which are quoted include genetic damage which may only be evident in later generations,[66] impairment of growth, reduction in intelligence and disease resistance.[67] The intrinsic complexity of such issues is further complicated, medusa-like, by the malign influence of multiple causation[68] and varying individual susceptibility.[69] Stapleton comments that,

> "[P]roof of medical causation is also extremely difficult where the disease was not due to, say, the victim's direct use of a product or direct exposure to hazardous work conditions, but where the source was more generally or indirectly dispersed in the environment. For these and other reasons the aetiology of man-made disease presents the most complex conceptual and practical challenges to both the tort system and

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[66]The recent debate over radioactive contamination at the Sellafield nuclear reprocessing facility, and the controversial advice to men working there, is a topical example of such a possibility. In this case, the apparently clear demonstration of a scientific link between the radioactive exposure and specific harm to the babies/children of the workforce, is not usually characteristic of such issues.

[67]Disease and the Compensation Debate, op. cit., at p. 33 et seq.

[68]Lawyers familiar with decisions such as Wilsher v. Essex Area Health Authority [1988] 1 All E. R. 871 (H.L.), McGhee v. National Coal Board 1973 1 W.L.R. 1 (H.L.) and Hotson v. East Berkshire Health Authority [1987] A.C. 750 (H.L.) will need little prompting to view causal issue as posing potentially huge difficulties to legal analyses. Of these three cases, only the facts of Wilsher genuinely disclose a multiple causation issue. The other two are included to show that apparently more straightforward cases may still create substantial problems.

[69]Disease and the Compensation Debate, op. cit., at p. 33.

"no fault" compensation schemes which are limited on the basis of cause of disability."[70]

Several points of difficulty accruing to the plaintiff in a man-made disease claim are articulated.[71] Amongst these are the fact that it must be shown that the (potentially tortious) hazard in question is in fact capable of causing the disease.[72] She argues that this will not be possible in many cases, and that the advances in aetiological understanding are slow and unsystematic. It is also stated that the low incidence and prominence of some claims is unlikely to provide an incentive for scientific investigation;[73] the scientific proof of these is doubtful,

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[70]Disease and the Compensation Debate op. cit., at p. 33. As regards Stapleton's comment on limited no-fault schemes, the writer will argue elsewhere that for medical negligence (and also mishap), a limited "needs-based" treatment/hospital compensation scheme is required. Although it is readily acknowledged that such a proposal is ultimately conceptually unsatisfactory, it will be argued that it is preferable to the existing system, and that it is an acceptable compromise between that and Stapleton's full "needs-based" compensation.

[71]Disease and the Compensation Debate, op. cit., at pp. 33 et seq.

[72]Disease and the Compensation Debate, op. cit., at p. 34.

[73]The "evergreen" advance of scientific knowledge has been cited as a reason for doubting Stapleton's comment on this. The writer shares Stapleton's pessimism on this issue: even if present-day hazard-producing activities are more fully understood in future, it seems likely that the rate of progress will produce in parallel a stream of new hazards in future. In other words, technological advancement is likely to continue to outstrip full understanding of its long-term consequences. This will be so if only because of the (currently) unavoidably small time-gap between discovering and utilising new technologies. It is further submitted that this reflects the present position, and is likely to continue for as long as notional "society" continues to think that the benefits of such advances outweigh the risks. See Principle and Pragmatism in the Compensation Debate, K. S. Abraham, supra, at pp. 306-307. Abraham's criticisms are dealt

quite apart from their legal proof.[74] The associated difficulties of distinguishing "guilty" causative agents from "innocent" ones are also discussed.[75] The potential to work injustice in some cases arising from the application of the balance of probabilities test is also examined in detail.[76] [77] One fundamental difficulty which is identified by Stapleton is that a tort claim may be based on omission to provide safety precautions in appropriate cases:[78]

> "[I]n such cases the burden which under traditional rules falls on the plaintiff involves much greater difficulty: to show that, on the balance of probabilities, the victim's disease was due to the omission. To do so, it must be shown that: (i) the victim would probably have used the omitted device or followed the product advice; and (ii) the omission of the device had more than doubled the likelihood of the disease (or exacerbation) which is the subject of the

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with generally infra.

[74]Some of Stapleton's examples would now have been overtaken by the strict liability regime in the Consumer Protection Act 1987, although the existence of the "development risks" defence perhaps suggests "reasonable care".

[75]Disease and the Compensation Debate, op. cit., at p. 42 et seq.

[76]An analysis and criticism of the case of McGhee v. National Coal Board, [1972] 3 All E. R.1008, is made by Stapleton, op. cit., at pp. 46-49. She argues inter alia that the court in McGhee abandoned the one-to-one relationship between damage accruing to the defender, and causal responsibility by the tortfeasor. It now seems that any possible ambiguity in McGhee which might be construed in favour of a defender is at least reduced: see inter alia Proof of Causation in Medical Negligence Cases, J. G. Logie, 1988 S.L.T. 25, and Further Reflections on Medical Causation, A. F. Phillips, 1988 S.L.T. 325.

[77]Disease and the Compensation Debate, op. cit., at pp. 39-42.

[78]Disease and the Compensation Debate, op. cit., at p. 44 et seq.

> complaint.....[A]gain, the fundamental problem is that the plaintiff can only deal in probabilities, but with omissions these are clearly much more difficult to assess. Firstly, there is an intrinsic difficulty in hypothesizing what a person's probable behaviour might have been in an imaginary situation..."[79]

A related difficulty to which attention is drawn is that of assessing in vacuo what the efficacy of the omitted precaution might have been. It may therefore be seen that, in such cases,[80] much of the establishment of a successful claim rests upon a highly abstract and speculative basis.

Some attention is also devoted in the argument to related issues, such as procedural and practical difficulties. However, the main emphasis of her argument is on the questions of proof of fault and of causation. We now consider how these factors lead to her conclusion that a compensation system based upon harm is required.[81] Stapleton's primary concern in discussing reform is the compensation goal, although deterrence and corrective justice are discussed.[82] Her rationale for the adoption of

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[79]Disease and the Compensation Debate, op. cit., at p. 44.

[80]Again, some of Stapleton's examples have been overtaken by the advent of the strict liability regime, under the Consumer Protection Act 1987. However, it is thought that her arguments are not unduly affected by this - if anything, they may be strengthened. Examples quoted by her include silicosis and byssinosis.

[81]Deterrence is discussed by Stapleton, supra, in chapter 6, primarily in terms of economic theories.

[82]"[B]ut the principal debate in England arises from the widespread acknowledgment that in substantial measure it fails to achieve its "corrective justice" goal, particularly its compensatory aspect."; Stapleton, op. cit., at p. 104. The comment is also made that, "[T]he contemporary focus on the

a needs-based compensation scheme is based on two main factors. One is that, by elimination, once the present structure of fault and causation is shown to be unsatisfactory, then the remaining criterion is that of harm or damage. Alternatively, Stapleton considers the extent to which preferential treatment is justified under a compensation scheme.[83] Once fault is rejected as a determinative criterion,[84] as she has already argued, it then becomes impossible to defend preferential treatment where based only upon causal criteria.[85] Arguments are also advanced from principle, requiring compensation based upon need.[86] This synthesis[87] is said to lead to harm as the touchstone of compensation; limited schemes[88] are also

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compensation goal together with a rejection of the tort system as its vehicle has led to a number of non-tort no-fault systems for compensating particular groups of victims."; Stapleton, op. cit., at p. 105.

[83]Disease and the Compensation Debate, op. cit., at p. 108 et seq.

[84]supra

[85]Disease and the Compensation Debate, op. cit., at p. 108-109.

[86]See, for example, Compensating Victims of Diseases, J. Stapleton, 1985 5 Oxford J. Legal Studies 248 at p. 253 et seq., and Disease and the Compensation Debate, op. cit., especially ch. 7.

[87]"The conclusion is that once the tort system is abandoned as an appropriate compensation mechanism there is no rational justification for preferential treatment of the disabled." Disease and the Compensation Debate, op. cit., at p. 115.

[88]I.e. pockets of strict liability and limited no-fault systems: see Disease and the Compensation Debate, op. cit., at pp. 108-118.

criticised as entailing problems of definition and scope, whilst retaining the aetiological difficulty in establishing causation.[89] [90]

Having set out her case for a needs-based system, Stapleton analyses several reform policy options.[91] These include the Australian and New Zealand no-fault schemes, earnings-related compensation systems, and other criteria both in principle and in practice.[92] Ultimately, it is argued that the expectations engendered by the tort system must be re-assessed. This is because they could never, on grounds of cost, be extended to satisfy the principle of comprehensiveness. In practical terms, Stapleton also

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[89]For a summary of this argument, see Disease and the Compensation Debate, op. cit., at p. 142. Stapleton points out that, by ignoring man-made disease, tort critics deprive themselves of the most potent argument against tort. This is stated to be on grounds both of compensation and deterrence. It is also shown that deterrence is of minimal efficacy in cases of man made disease, because of their insidious and long latency characteristics.

[90]It may be thought that Stapleton concentrates too much upon man-made disease, and that therefore her conclusions for the tort system as a whole do not follow. However, in reply, it must be pointed out that a large part of her argument is based on distortions in compensation. If this is accepted, then it is hard to justify retention of such a system. Despite this, however, Stapleton's criticism of the operation of deterrence in respect of man-made disease does not establish that deterrence is either undesirable in principle, or unworkable, in other areas of the law of negligence.

[91]Disease and the Compensation Debate, op. cit., at pp. 142-169.

[92]Disease and the Compensation Debate, op. cit., at pp. 143-169.

acknowledges that establishing a comprehensive needs based compensation system cannot be done quickly.[93]

Thus the first step in Stapleton's reform proposals is to introduce a scheme which covers disease rather than accidents.[94] Several possible separate funds are canvassed, including the alleviation of income disruption, incapacity, or flat-rate or earnings related state benefits made over in return for an assignation of the rights in tort of the victim.[95] The choice of scheme would reflect the values and priorities of the policy-maker.

It may thus be seen that, although Stapleton argues in favour of the comprehensive, needs based compensation goal, and discusses deterrence (in the context of man made disease), her conclusions reflect a flexibility: this, it is submitted, is desirable. It need not undermine the arguments advanced, but recognises the practical difficulties of constructing a fully comprehensive system. In acknowledging these factors, Stapleton argues for either an alleviation of the shortcomings in tort visited upon man made disease victims, or a systematic reform designed to

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[93]Indeed, Stapleton comments that, "(T)he idea of comprehensive cover may itself be rejected outright in the light of practical and/or policy considerations." Disease and the Compensation Debate, op. cit., at p. 169.

[94]Alongside the comprehensive goal. This step would in practice remedy many of the distortions evident at present.

[95]See Disease and the Compensation Debate, op. cit., at pp. 158-183, and Compensating Victims of Disease, op. cit., at pp. 266-268.

eliminate indefensible distortions in principle and practice. We may now turn to a systematic critique of these arguments.

Abraham's counter-arguments

Although Abraham states that he is "largely sympathetic"[96] to Stapleton's views, if the implications of his critique are accepted, then little remains of the original thesis.

Abraham's first point is that it is not established that man-made disease is a numerically significant problem.[97] He concludes from this that if so, the fact that such victims are unable to obtain compensation is not of "great moment".[98] Doubting the validity of the examples of adverse drug reactions[99] and asbestosis and others, he argues that the size of the class is not established. He describes man-made disease as a "possibility".[100] There is nothing, he adds, to prove that in future, circumstances will arise which will give rise to man-made disease.

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[96]Principle and Pragmatism in the Compensation Debate, K. S. Abraham, 1987 7 Oxford J. Legal Studies 302-308.

[97]Abraham, op. cit., at p. 303.

[98]Abraham, op. cit., at p. 303.

[99]These of course would now fall within the ambit of the Consumer Protection Act 1987, and its strict liability and development risks defence.

[100]Abraham, op. cit., at pp. 303-304.

The second criticism is that Stapleton has not adequately made out her argument that there are major conceptual and procedural barriers to recovery of damages by man-made disease victims. Abraham founds on the fact that, whilst ostensibly considering the British aspects of this debate, Stapleton makes copious reference to American cases.[101] Thus, Abraham argues that the wider American experience is germane to her conclusions. The transatlantic experience, it is argued, shows that the admittedly high barriers to recovery in man-made disease and similar cases are being relaxed to a degree. This, plus several other alleged advantages of American practice,[102] is put forward as "closing the gap"[103] between defendant and plaintiff. However, other commentators, such as Atiyah, would disagree fundamentally with this.[104]

However, a further argument advanced against Stapleton's views is Abraham's third and final one. He disputes the proposition advanced by Stapleton that man-made disease is not susceptible of deterrence by the tort mechanism. His position is that where deterrence is achieved by tort, then this excuses - and indeed justifies

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[101]Abraham, op. cit., at pp. 304-305.

[102]Such as contingency fees, class actions and "market share" liability: Abraham, op. cit., at pp. 304-305.

[103]Abraham, op. cit., at p. 305.

[104]No-Fault Compensation: A Question That Will Not Go Away, P.S. Atiyah, 1980 Insurance L.J. 625, at p. 628 et seq.

- non-uniform compensation.[105] Whilst acknowledging the difficulty of deterring (and proving) the non-traumatic harm accruing from human activities, it is argued that the future may well bring a greater understanding of the hazards and aetiology of such human activities. Were this the case, it would be possible eventually to construct a third-party insurance scheme so arranged as to penalize, by cost of premiums, the authors of the highest risks. This, of course, would render the existing system far more efficacious in providing compensation than it is at present.[106] Vennell has commented that "[U]nfortunately there is very little information available as to whether or not the possibility of a civil claim, or the law of torts itself, acts as a deterrent."[107] More seriously, Abraham goes on to consider the wider question of needs-based compensation.[108] This is based on the view that the tort system has engendered a high expectation of compensation in the public, and that to reduce significantly the level of recompense under a new system would at the least be

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[105]Abraham, op. cit., at p. 305 et seq.

[106]This indirect admission appears to underly various of Abraham's comments.

[107]The Scope of National No-Fault Accident Compensation in Australia and New Zealand, M.A. Vennell, 1975 49 Australian L. J. 22, at p. 23.

[108]This is described as loss-based by Abraham, op. cit., at p. 307.

undesirable.[109] Ultimately, Abraham admits that the tort system has raised feelings of entitlement to compensation that in some cases it is unable to satisfy. Then, accepting that a disease- or loss-based system would not, at least initially, be able to compensate all according to need, he asks whether by comparison the present accident preference in tort is unjustifiable. He concludes that "a needs principle may...be the proper touchstone for evaluating the justice of modern compensation schemes. But there is a difference between an argument from such a principle, and an argument for it....[T]he practical success of her proposals...probably will depend a good deal more on the ability of reformers to explain why that principle should be adopted."[110]

It may be seen from this debate that departure from uniform, needs-based compensation may be unavoidable. This may be on grounds of principle or practicalities or both. Ultimately, it may be conceded that such a response is unsatisfactory. So far as criticism by Abraham on the argument to needs-based compensation is concerned, it is submitted that it is implied, although perhaps not express, within the greater premise of Stapleton's argument. This argument would presumably run along the lines that as similar injuries or disabilities cause equal suffering to

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[109]Cf. New Zealand's no-fault answer, M. Whincup, 1988 N.L.J. 474 at p. 475.

[110]Abraham, op. cit., at p. 308.

their subjects, then prima facie no class of subjects should be denied such financial relief as is available on grounds of cause. The cause, by the time the injury had occurred, would be irrelevant to the degree of suffering. In cases of equal suffering, there would be equal need for financial amelioration. An extension of this argument, and one which it is thought is not necessary to establish Stapleton's point in favour of needs-based compensation, is that all individuals suffer equally from equivalent conditions, and that because of this, they should be compensated equally, if compensated at all, for misfortune. However attractive this argument may be, it must be balanced against the counter-proposition which this suggests. The counter-argument is that there must be some limit to what is the subject of compensation, otherwise a notional norm (or ideal) would be needed against which all deficiencies or deviations would attract compensation. This would entail, if pursued, compensation for everything imaginable - which would import the familiar judicial "floodgates" argument about uncontrolled compensation and in turn expenditure. An interesting issue has been the (now successful) pressure upon the U.K. Government for compensation for haemophiliacs who acquired the H.I.V. virus through blood transfusion.[111]

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[111]Haemophilia, AIDS, and no fault compensation, P. Jones, 1987 B.M.J. 944.

In this context, it is interesting that delict/tort compensation perpetuates inequalities in various ways. Not only does the aetiology of the injury or disease impose these, but once the legal requirements are satisfied, the way in which damages are calculated also does so, especially where they are calculated on loss of earnings, which accepts ab initio that individuals vary in earning capacity. However, it is thought that in general anomalies and inequalities should be avoided by a legal system unless strong reasons may be adduced in justification.

So far as compensation for medical negligence is concerned, as soon as the ambit of this is attempted to be defined, difficulties of causation (and of scope[112]) immediately arise. In turn, this pre-supposes that the victims of medical negligence are treated differently from other accident, delict and disease victims. But in the light of these arguments, it is thought that an ideal mechanism for compensating those who suffer injury from medical negligence would be to include them in an expanded social security system which would compensate according to need and not cause, in resource terms to whatever the extent that society generally would be willing to fund. Such a decision, and the level of resources devoted to it,

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[112]The New Zealand scheme did not actually abolish the tort remedy of damages; it merely rendered it unavailable. It has been argued that even this may permit some residual tort deterrent effect to linger, although the present writer is sceptical of this. See, Some Kiwi Kite-Flying, M.A. Vennell, 1975 N.Z.L.R. 254 at pp. 255 - 257.

would require to be considered in the appropriate democratic fora. In order to mitigate the "floodgates" risk, a (problematic) set of criteria would need to be developed to restrict compensation to more tangible, substantial injuries and to exclude all minor or cosmetic deficiencies. It must be conceded that, apart from the issues of principle involved, this would be at some risk of being impracticable and expensive. Such an approach, though, might be amenable to risk analysis and management.[113]

In the light of the "principle of scarce resources", the approach proposed is a compromise, although it is conceded that this re-introduces causal criteria. This is felt to be unavoidable short of full-scale compensation according to need. Thus, those who suffered injury from medical negligence would have in common that the medical quality control groups, and/or Medical Audit Boards, would have considered their case in the context of the standard of care. Such a category of claimant would already have been identified, and his or her medical condition assessed. It is submitted that (ideally) an appropriate independent doctor, if resources should permit, failing which the proposed body, should also make a determination as to

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[113]The Institutionalization of Risk, A.J. Reiss, 1989 Law and Policy 392. Risk management and analysis has been examined within the nuclear power industry for some years: Managing Risk: Managing Uncertainty in the British Nuclear Installations Inspectorate, P.K. Manning, 1989 Law and Policy 350.

whether a patient was entitled to compensation. This would not involve any consideration of whether the doctor or other medical personnel had been negligent but would simply reflect that individual's need. Criteria similar to those utilised in the Swedish system (as to aetiology) would be needed to exclude non-iatrogenic harm from compensation, unless a full needs-based system were adopted, and resources so permitted.[114] If this determination were made by the bodies responsible for monitoring the standard of care, this would be justified on the grounds of practicality and economy, in the light of the arguments advanced above regarding the separation of assessment of the standard of care and the provision of compensation.[115] The compensation thus allowed would be administered and paid through the relatively efficient and inexpensive conduit of the social security system; it would be up to the claimant to forward his certificate to the social security authorities to claim his entitlement. It is also suggested that in order to simplify the payment of compensation, a "banding" system be devised whereby in several tiers, levels of compensation suitable for varying

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[114]Arguably avoiding issues of scope which have bedevilled the New Zealand scheme, for example whether pregnancy and childbirth following a failed sterilisation came within the scheme. See Accident Compensation and Childbirth, J. Hughes, 1981 N.Z.L.J. 79.

[115]Cf. Incentive Issues in the Design of No-Fault Compensation Schemes, M.J. Trebilcock, 1989 39 Univ. Toronto L. J. 19, at p. 45 et seq.

levels of disability, injury or pain be provided. Of necessity, criteria would require to be devised in order to prevent the system being overwhelmed with a mass of trivial applications.[116] It is proposed that criteria such as whether pain is suffered and its nature and degree, whether an individual's normal life and activities are curtailed and to what extent, whether time absent from work in excess of a certain number of days (ten is suggested), and similar, be applied.[117] Such a scheme, grafted on to the existing social security arrangements, would, it is submitted, be relatively inexpensive and efficient and would avoid the complication, delay and expense of litigation. Furthermore, it is arguable that the arrangements for Crown indemnity, which allow a certain "pooling" of claims payments to be made between authorities (slightly analogous to an insurance scheme for Crown bodies, not normally able to insure), represents a step towards such a reform.[118]

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[116]In Holland, anyone who loses over 15% of their earning capacity because of disease receives compensation. Causation is, other than this minimal threshold requirement, not considered. However, concern is mounting at the recent 13% proportion of the workforce claiming under this scheme, payments amounting to a 5% budget of the Dutch national net income: "13% of Dutch workers "disabled" ", J. Verbeek, 1991 B.M.J. 1495 at pp. 1495-1496.

[117]The details of such an approach would be subject to review and research.

[118]See Who pays for clinical negligence? J. Tingle, 1991 N.L.J. 630, at p. 631.

The amounts of compensation payable would in turn be determined by the resources devoted to the scheme. This would ultimately be determined democratically in the light of ambient economic conditions. It is envisaged that Parliament would determine the matter. If the affordable initial level of resources was too low to provide meaningful compensation, despite the suggested limitations above, it is acknowledged that a choice as to whether to adopt the new scheme in preference to the existing arrangements would then have to be made. Nevertheless, readers are referred to Chapter VI and to the submission reported therein, that the £50 million currently spent on compensation for medical negligence could be re-deployed to provide sufficient funding for a no-fault scheme. It is submitted that savings in the cost of litigation would also result from an alternative compensation mechanism; in Sweden, 14% of the Patient Compensation Scheme's budget is spent on administration[119] and few take up the tort litigation option.[120] The average delay before compensation is paid under the Swedish system is two months.[121] In support of some reform of compensation may be cited

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[119]Dealing with Medical Malpractice: The British and Swedish Experience, M.M. Rosenthal, Tavistock, 1987, at p. 176.

[120]King's Fund study, supra, at p. 23.

[121]Rosenthal, op. cit., table 19, at p. 180.

pressure towards regular payments of damages within so-called "structured settlements".[122]

This proposal has been made on the premise that this might be a first step towards a needs-based scheme which in its entirety might be too expensive, or alternatively that the existing arrangements for medical negligence claimants require reform. However, it is submitted that it is possible to advance arguments in favour of a seemingly preferential system for such individuals. The most obvious approach is that the existing arrangements purport to treat this category of claimant equally with other sufferers of delictual injury. If this is correct, it is submitted that it fails adequately to achieve this goal. It has already been seen that medical negligence claims are more difficult and time-consuming to sustain than other comparable claims.[123] Thus the argument in favour of preference reverts merely to that of restoring this class to the status quo ante. Alternatively, it might be argued that the state, in providing the National Health Service, has a moral obligation which should be reflected in potential legal liability to those of whose injuries it has been the author. The counter-argument is that it is enough to provide such a service for the general good, and that episodes of harm-causing negligence are an unavoidable

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[122]E.g. Structured settlements - an unexploited opportunity, H. Witcomb, 1990 N.L.J. 88.

[123]See chapter I and chapter VI.

price to pay for its general benefits. This approach involves a similar risk/reward analysis but with different starting values.

However, if compensation were provided to everyone with a disability, measured upon an abstract scale of seriousness, then the mere fact that the route to that compensation by one individual happened to be via a medical audit board or similar, which society had decided to incorporate within the broad outlines of its social security system, would not infringe arguments against preferences. Inasmuch as presently disadvantaged, the victim of medical negligence may be seen as analogous to Stapleton's victim of man-made disease. If he has suffered through exposure to a mechanism which society has provided, and perhaps which a patient has no choice but to utilise,[124] then ensuring compensation may become a rational preference or goal supported from a desire not to engender unnecessary suffering in consequence of state provision. Practical difficulties, such as those of the patient's understanding of the way in which his injury arose,[125] may also justify preferential compensation, if the present proposal indeed is such. It is also envisaged that generally for a patient (and a doctor, mutatis mutandis) there would be a right of

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[124]If unable, say, to afford private medical care.

[125]Which would not arise in many other categories of injury regulated by the delict/tort system, such as road traffic injuries.

appeal to a higher medical tribunal, and thence one further appeal to a court of law of equal or greater rank to the Court of Session. For the doctor, this would be if he had been censured as to his professional conduct; for the patient only if a procedural mistake or equivalent abuse of discretion had taken place. The election which the patient would have made originally to avail himself of compensation under the proposed scheme would not be invalidated by such an appeal; he would not be permitted to make a claim in delict or tort at this stage in the proceedings but merely to obtain a judicial review of the exercise of the procedures. The main assessment of compensation for medical negligence under the proposed scheme would, it is suggested, be undertaken by general practitioners; some payment, preferably small, would clearly require to be made to such doctors for this. It is suggested that a system of tiers of compensation would reduce the resources required in this context to the minimum, at some cost in accuracy. It is also suggested, with hesitation, that unless in receipt of social security benefits, claimants be required to pay this themselves simply to reduce the financial burden upon the proposed scheme.

So far as the provisions dealing with the standard of care, accountability and deterrence are concerned, these have already been adverted to. Although evidence and data regarding negligent practices are virtually non-existent,

there is a certain amount of evidence that some of the symptoms are

> "...deficient data from case-notes....inadequate provision of emergency services, low necropsy rates, poor supervision of junior staff (particularly senior house officers in anaesthetics),[126] and surgeons operating outside their specialty..."[127]

It is worth recapitulating that the proposed reform envisages the equal importance of compensation and (broad) deterrence, and that two methods would primarily be used to detect cases in which an audit of clinical judgment would be carried out. The first of these is the patient-driven reporting system. Any adverse outcomes, especially if unexpected, causing disappointment, could be included within this. As the clinical audit system would only be linked to a simple assessment of compensation, inasmuch as economy of resources required the same bodies to adjudicate, and not as a mechanism for actually providing it, it would be likely to detect and resolve cases in which previously there would have been a desire for a simple explanation and apology. This might reduce the number of claims and the potential bitterness of some patients

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[126]In relation to this, the writer has already argued (supra, ch. 2) that the law does not allot sufficient liability and responsibility to those who supervise junior doctors. This is included within the proposed scheme.

[127]This refers only to deaths surrounding surgical operations. N.C.E.P.O.D.: Revisiting perioperative mortality, N.W. Morrell, W.A. Seed, 1992 B.M.J. 1128, at p. 1128.

arguably fostered by the present adversarial system.[128] Against this it could be argued that there is a risk of a flood of complaints. This possibility is acknowledged by the writer, and the system might have to be restricted in order to contain it. Equally, it is arguable that claims would be better dealt with under this scheme than to proceed to a long, expensive and more stressful litigation. Furthermore, it is submitted that such a scheme would meet Brown's objection, to both fault and no-fault schemes, that deterrence is only available by a risk-rated premium or contribution system.[129]

If a patient wished to make a report under the proposed system, he would be barred from exercising a remedy in litigation on the grounds of negligence, and thus would be obliged, if compensation was desired and appropriate, to apply under the compensation mechanism. It is anticipated that few would opt to exercise a remedy in delict, as in Sweden.[130] Inasmuch as the proposed approach overlaps with existing complaints procedures, it is

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[128]There is some evidence from a large Danish study that those most likely to be dissatisfied with treatment are the elderly and those who have received or are receiving higher education. See, Patients' Dissatisfaction with Medical Treatment and Their Reaction, E. Segest, 1988 Medicine and Law 205.

[129]Deterrence and Accident Compensation Schemes, C. Brown, Univ. of Western Ontario L. Rev. 111, at p. 154.

[130]Supra. Finland operates broadly similar no-fault compensation schemes to those in Sweden. See inter alia "No Fault" in Finland: paying patients and drug victims, M. Brahams, 1988 N.L.J. 678.

submitted that these should be subsumed within the proposed system, as its scope would be wider. For clarity, the self-reporting by doctors would be wholly confidential (i.e. could not give rise to disciplinary consequences) in order to encourage their participation in the suggested scheme; however, matters raised by patients (and others) could, whether or not already self-reported by the doctor, be referred by the proposed bodies to the G.M.C. if necessary. It is submitted that this would improve the efficiency and efficacy of the proposed scheme and medical practice; thus, complaints would be included within it and automatically dealt with at the most appropriate level, as discussed elsewhere.

Apart from this, the main mechanism by which the medical audit or quality control system would operate would be by the suggested Medical Audit Board. As has been mentioned above, this body would undertake several functions. If a patient were dissatisfied by the consideration given to his report by the medical audit group of local doctors at first instance, he would be able to appeal to the Medical Audit Board. Its personnel would comprise doctors, perhaps academic doctors, qualified in the same medical discipline as those being considered, and a lawyer. The approach of the Board, and also of the quality control circles and peer review audits presently

being introduced into the N.H.S.,[131] would not be adversarial but inquisitorial, and would not be disciplinary or judgmental, although (as mentioned) clearly a power to report doctors to the General Medical Council would be needed to cope in suitably serious cases. It is not thought that the proposed scheme would substantially affect the operation of the disciplinary machinery of the latter, or the operation of Fatal Accident Inquiries where appropriate to the present discussion. In addition, the proposed Boards, like the Mental Welfare Commission, would be required to undertake a study of samples across varying specialties as a random investigation of the standard of care. The composition and qualification of Board members would clearly require to be varied as appropriate for such exercises. This partly pro-active jurisdiction could not cover all medical treatment, and indeed could not be expected to, but would nevertheless constitute an additional check and balance. It is suggested that it should seek to audit a certain proportion, perhaps between two and four per centum, of consultations across the range of hospital and general practice. Private medicine, it is thought, would not initially be included within this mechanism, but could be included subsequently if appropriate, and in the light of experience. The Board's

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[131]See generally, The appropriate use of diagnostic services: (xiii) Medical audit in clinical practice and medical education, D.A. Heath, 1986 18 Health Trends 74.

primary function would be the improvement of the standard of care, and its findings, in order to safeguard its independence and non-disciplinary character, would be inadmissible in (any legal and) G.M.C. proceedings against doctors and health boards, authorities or opted-out N.H.S. hospitals. The G.M.C., if a matter were referred to it, would thus require to conduct its own independent investigation. The standard of care which such a Board would operate would be that of "acceptable practice":[132]

> "[N]o matter whether the doctor is held liable for negligence or whether there is insurance coverage for medical misadventure, decisive is whether or not the treatment measures up to the standard of medical science at the time of the treatment."[133]

This would combine a substantially objective approach tempered with subjective elements: some allowance could therefore be made for a junior doctor who had been on duty for extended hours,[134] or who had not been sufficiently supervised. The difficulties in interpretation of medical evidence, exemplified in Hughes v. Waltham Forest Health

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[132] supra

[133] Medical Malpractice and Medical Misadventure in New Zealand: Public Insurance in Lieu of Private Liability as Administered by the Courts and the Accident Compensation Commission, E. Deutsch, 1982 Medicine and Law 345, at p. 353.

[134] A junior doctor has been held in England to have a right of action against his employing health authority where damage to his health arose through working excessive hours: Johnstone v. Bloomsbury Health Authority 1991 2 W.L.R. 1362.

Authority,[135] would be greatly reduced. Furthermore, the basic separation of assessment of the standard of care and compensation would reduce the impact and complexity of causal enquiry; this could only be removed entirely by the adoption of a needs-based compensation system with wholly separate accountability provisions. It is suggested that, as with the courts, the proposed Board's meetings would be open for patients, doctors and their relatives to attend. This would not be compulsory, unless they were required to be interviewed or examined by the Board, and the emphasis would be upon openness, explanation and the avoidance of future mishaps. Although as it is conceived this would apply to adverse outcomes and patient disappointment, the primary, de facto focus of the scheme would be upon cases of medical negligence. However, if resources and experience with the scheme were to suggest it, such a system could be widened to incorporate all "medical accidents" or even be adapted to assess compensation in the event that a needs-based compensation scheme were ever adopted. These suggestions seek to enhance accountability, reduce antagonism and the adversarial characteristics of the present system,[136] and improve the standard of care.

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[135]In the Court of Appeal. Reported in Medicine and the Law: Conflicts of Medical Evidence, D. Brahams, 1991 The Lancet 841-842. See also generally, Complaints against Medical Practitioners, M.C. Meston, 1989 S.L.T. (News) 69.

[136]See, Alternatives to Litigation: Factors in Choosing, J. Effron, 1989 52 M.L.R. 480.

Conclusions

This thesis has attempted the ambitious task of trying to identify, diagnose and suggest treatment for the ills of the legal mechanisms for dealing with medical negligence, in addition to setting out the main substantive principles of the relevant Scots law. It has also sought to explain the working of the main driving principles behind the appropriate body of law, and to examine and criticise the deficiencies in the present approach. However, it is thought that there should be a balance in such assessments, and it is submitted that the plight of a doctor accused of negligent practice should be considered just as that of the patient. Similarly, criticism should ultimately be constructive rather than merely destructive. Accordingly, the writer has sought to identify the aims of the present system, and to avoid discarding these with aspects of their incarnation into the current legal regime. These aims appear to be worthwhile ones, and they have therefore formed the underpinning principles for the writer's proposals for reform. Whilst acknowledging that reservations must inevitably accompany them, the foregoing suggestions are put forward not as a complete solution, but rather as a starting point for consideration of reform of the present system for dealing with medical negligence. It is accepted that they are unlikely to provide a panacea.

However, the writer is concerned that the present system perpetuates unnecessary difficulties[137] and stresses for both sides[138] of litigation in medical negligence - about which a system of justice must be vigilant and strive to minimise. If the analysis in this thesis, and these suggestions for improvements, assist in this process or its consideration in any way, the aims of the writer will have been amply fulfilled.

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[137]See, A Review of the Civil Justice Review: Economic Theories Behind the Delays in Tort Litigation, T.M. Swanson, 1990 43 Current Legal Problems 185.

[138]As regards the defender who is a professional sued for negligence and its effects, see The professional man and the spurious claim, O. Catchpole, 1990 N.L.J. 1043.

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